Nebraska's Public Mental Health And Substance Abuse System:

A Status Report With Recommendations For Improvement

January 5, 2001

Nebraska Health and Human Services System

PREFACE

On November 27, 2000, the Policy Cabinet of the Health and Human Services System (HHSS) met with Regional Program Administrators, Regional Center CEO's and representatives of the HHSS Division of Mental Health, Substance Abuse, and Addiction Services, and asked them to develop and submit to the Policy Cabinet a strategy for responding to the problems being encountered in the state's public mental health and substance abuse system. This system has invested significant resources over the last five years to improve its operations. Despite a number of significant improvements, its success in meeting the needs of consumers continues to be limited by the availability of and access to services resulting from a chronic under funding of the system.

This report describes the problems currently confronting the Nebraska Behavioral Health System (NBHS), provides an analysis of the causes of those problems, and makes recommendations as to how these problems should be addressed. Finally, the report outlines the next steps that should be taken to address the most critical problems.

ACKNOWLEDGEMENTS

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TABLE OF CONTENTS

INTRODUCTION

This report has been prepared in response to a growing awareness of the problems being encountered within the state's public mental health and substance abuse system. This system, also known as the Nebraska Behavioral Health System (NBHS), was established by the Legislature in 1974. LB 302 established the system's purpose:

> *The act is intended to organize and provide for methods of financing community mental health facilities, programs, and services, to provide for more effective utilization of existing mental health resources, to provide a means for participation of local communities in the determination of the need for and allocation of mental health facilities, programs, and services, to provide a means to grant state mental health funds as appropriated for community needs, to define administrative structure, and to coordinate and integrate such programs with other human services.*

The Alcoholism and Drug Abuse Act (LB 204) passed in 1977 specifically incorporated substance abuse services into this existing structure. A more thorough description of how the system is organized is provided in Attachment 1.

Mental health and substance abuse services are delivered through a combination of public and private resources. Private resources devoted to mental health and substance abuse services have been diminishing over the past several years due to reduction in insurance benefits. This has resulted in a shift in consumers from privately financed services to the public system.

State and local government are the principal payers for mental health and substance abuse services (according to Mental Health: A Report of the Surgeon General, December 1999) with federal participation provided through federal block grants and the Medicaid and Medicare programs. Public mental health and substance abuse services are funded through regional entities and through direct contracts.

The State of Nebraska supports the delivery of mental health and substance abuse services through the community system, the Nebraska Behavioral Health System (NBHS.) The NBHS is comprised of six locally administered regions, which contract with providers to deliver services. The state's three Regional Centers provide inpatient and secure mental health services as part of this system.

NBHS primarily serves the non-Medicaid population of adults and youth with or at risk of serious mental illness, substance abuse and/or substance dependence. These individuals are typically low income and uninsured. (The mission and vision of NBHS are described in Attachment 1). NBHS primarily serves the public, non-Medicaid eligible population and is the payor of last resort.

HHSS also contracts directly with Native American tribes to provide mental health and substance abuse services and for a variety of other community mental health and substance abuse services.

THE PROBLEM

The public system is facing a serious crisis. Individuals experiencing mental health and substance abuse problems are having difficulty accessing appropriate services in a timely manner. This is evidenced by:

- The current crises in the emergency system (i.e. increase in post commitment days)
- The increased number of individuals with substance abuse problems committed to Regional Centers
- Extensive waiting lists to receive community substance abuse and mental health services,
- A fragmented process for transitioning consumers from Regional Centers to the community,
- Inadequate capacities for services to meet consumer need in the community, both rural and urban, and
- An increased number of individuals needing mental health and substance services who do not have health insurance coverage.

Although there are serious issues with the delivery of children's mental health and substance abuse services, this report addresses primarily the problems being experienced in adult services. Prevention services are also not addressed in this report.

ANALYSIS OF THE CURRENT SITUATION

The problems being experienced in the NBHS are primarily the result of the demand for services exceeding the availability of services. The current level of funding restricts the ability to add service capacity to meet the changing demand. Three other factors also impact the current situation: the rates paid for services; effectiveness of system operations; and the changing nature of the population requiring services. These factors are impacting each of the state's six regions.

DEMAND FOR SERVICES

The community-based mental health and substance abuse system serves approximately 30,000 consumers per year. HHSS estimates that the number of persons "Likely to Demand" mental health and substance services from the NBHS during 1999, was 44,886.

MENTAL HEALTH	Number Needing Services	Number Likely to Demand Public Services
Adults with any DSM diagnosis (excl. substance abuse), not Serious Mental Illness (SMI)	224,890	4,993
Adults with Serious Mental Illness (SMI)	36,667	5,134
Adults with Severe & Persistent Mental Illness (SPMI)	33,000	18,184
Subtotal	261,557	28,311
TOTAL SERVED FY 00*		20,218*

SUBSTANCE ABUSE	Number Needing Services**	Number Likely to Demand Public Services
Adults with Substance Abuse Problems	82,873	16,575
TOTAL SERVED FY 00*		9,996*

* *The number of persons served does not include all individuals served. As noted in this report not all providers supply information for consumers receiving outpatient or other low intensity services not paid for on a fee for service basis*

** *The need for alcoholism and substance abuse services represents those individuals with alcohol or substance abuse and/or dependency diagnosis.*

Federal guidelines for federal Mental Health and Substance Abuse Block Grant applications were used to make the estimates in the table above. These guidelines were developed in 1996 and are currently being updated. Because of this the *Number Likely to Demand Public Services* may be underestimated for the reasons discussed in this report.

The number of people seeking mental health and substance abuse services from the public system is increasing as evidenced by wait lists, increases in post commitment days, and increased lengths of stay at Regional Centers. Several factors are contributing to the increased demand:

- Insurance companies are limiting their liability for claims for mental health or substance abuse services. In Region V, for example, the number of people uninsured and needing acute mental health care increased from 202 during FY 97 to 480 during FY 99. This is an increase of 138 per cent in two years. This is the result of insurance companies seeking to avoid the high cost of long-term intensive psychotherapy and extensive hospital stays ("Mental Health: A Report of the Surgeon General").

- Managed Care for the insured population has impacted public resources by increasing the number of individuals seeking services through the public system. By denying services or limiting benefits, consumers are forced to look to the public system for these needed services. In addition, the reduction in rates paid to providers has resulted in a decrease in the number of mental health and substance abuse providers. For example, the number of acute inpatient mental health beds in Omaha has decreased from 357 in the 1980-90's to 131 in 1999.

- The closure of Veteran's Administration Hospitals and clinics has resulted in movement of the veteran population into the NBHS system, especially with respect to substance abuse.

- The lack of children's services has resulted in an increasing number of referrals of adolescents to adult services, especially to residential care that is developmentally inappropriate. The first six months of fiscal year 2001 has seen a 100 per cent increase in the number of state wards referred to NBHS adult services. The individuals referred have needed primarily substance abuse services.

- The number of state wards is increasing on an annual basis. For example, in 1995 there were 4,688 state wards. In 1999, there were 6,431 state wards. Many families are forced to make their children wards of state to access services.

CURRENT SERVICE CAPACITY

The current capacity of mental health and substance abuse services in the community is inadequate to meet consumer demand.

Mental Health and Substance Abuse Services. The fact that the demand for mental health and substance abuse services exceeds current capacity is by:

- Extensive wait lists for individuals requiring mental health and substance abuse services in the community. Region VI (Omaha area) reported that on November 30, 2000, there were 59 individuals on wait lists for substance abuse and 197 individuals on wait lists for mental health services. For the same date, Region V (Southeast Nebraska) reported they had 286 people on wait lists for substance abuse services and 187 on wait lists for mental health services.

- More than 100 of the 164 consumers displaced when Paxton Manor closed in July 2000, required mental health services, which were not available in the community. While capacity to serve these individuals was created by using private funds to build a facility, deficit funding was required to pay for providing services. This short-term solution has not resolved service capacity issues in Region VI.

- Access to community services needed by consumers ready to be discharged from a Regional Center is unavailable or extremely limited. On November 30, 2000, 39 of the 316 patients at Regional Centers were ready for discharge to the community. On that date, the Norfolk Regional Center reported that 18 discharge ready individuals required Residential Rehabilitation services. On the same date, there were 65 consumers on a wait list for Residential Rehabilitation services in Region VI. The services most frequently identified as being needed by these consumers were; Intermediate and Residential Rehabilitation services, assisted living, Short Term Residential (Substance Abuse), and independent living.

- A 274 per cent increase in post commitment days (the number of days individuals are hospitalized awaiting transfer to the Regional Centers following Mental Health Board hearings) in Regions IV, V, and VI since July 1999. In July 1999, 78 post commitment days were reported in these Regions. In July 2000, 292 were recorded. This increase was due to a lack of adequate community-based treatment alternatives.

- Regional Centers are reporting increased length of stays during the last year because there is an inadequate number of community services to which consumers can be discharged. The median lengths of stay have increased as follows:

	Median Length of Stay	
	FY 1999	FY 2000
Hastings Regional Center	28.0	31.0
Lincoln Regional Center	60.0	65.5
Norfolk Regional Center	87.0	104.5

- Substantial increases in lengths of stay reduce the number of consumers who can be served by the Regional Centers.

- On November 20, 2000, 22 sex offenders were patients at the Regional Centers. From 1992 to 1997, the system averaged seven sex offender commitments per year. The average for 1998 to 2000 is 20 per year, with projections of 20 to 30 per year for the years 2001 and 2002. This is a new population not previously served by Regional Centers as part of their mental health or substance abuse capacity. The result is fewer beds being available to mental health commitments and the Regional Centers no longer being able to accept voluntary admissions.

- The transfer of inmates from the Department of Correctional Services is also impacting capacity. Hastings and Lincoln Regional Centers are now averaging 20 to 24 inmate transfers total per year. These inmates become long-term residents at the Regional Centers, also resulting in reduced capacity for those individuals traditionally served by Regional Centers.

- In 1997, an estimated 13,500 adult arrestees in Nebraska needed some level of substance abuse treatment. Less than five per cent of adult arrestees actually received services ("Substance Abuse Task Force Report," January 2000.)

- The wait lists for Native Americans needing residential services.

Supported Housing. There is also an inadequate number of mental health supported housing alternatives for individuals with mental illness. Assisted Living beds for the mentally ill are in short supply and funding for these beds is not adequate to ensure necessary supportive services. On November 30, 2000, Regional Centers identified 50 patients who were expected to need assisted living services upon discharge. Since access to these services is limited, consumers are retained in higher levels of care such as Residential Rehabilitation services.

SYSTEM FINANCING

The level of funding provided to NBHS directly impacts the availability of and access to services. Regions are limited in the capacity of services that can be provided by the level of funding appropriated by the Legislature and approved by the Governor.

Current Funding of Mental Health and Substance Abuse Services. Appropriations for the current fiscal year (FY 01) to the community-based public mental health and substance abuse system are shown in the following table:

MENTAL HEALTH – Program 366 Appropriations

General Fund	$18,933,411
Federal Fund (Est.)	9,584,930
TOTAL	$28,518,341

SUBSTANCE ABUSE – Program 034 Appropriations

General Fund	$5,521,139
Cash Fund	1,354,507
Federal Fund (Est.)	7,453,873
TOTAL	$14,329,519

The current fiscal year budgets for the three Regional Center total $56,338,501. A breakdown by Regional Center is shown in the following table:

REGIONAL CENTERS – Program 365 Appropriations

Hastings Regional Center

General Fund	$16,658,612
Cash Fund	736,048
Federal Fund	927,505
TOTAL	$18,322,165

Norfolk Regional Center

General Fund	$11,652,704
Cash Fund	1,039,555
Federal Fund	1,730,814
TOTAL	$14,423,073

Lincoln Regional Center

General Fund	$17,787,451
Cash Fund	4,282,409
Federal Fund	1,523,403
TOTAL	$23,593,263

The level of mental health and substance abuse funding within the state of Nebraska is revealed in the following statistics:

- Per capita expenditures in Nebraska for community-based mental health services during FY 1997 equaled $8.36. The national average was $32.00 per capita. Nebraska ranked 49th nationally based on per capita in spending on community mental health, based on the survey conducted by the National Association of State Mental Health Program Directors (NASMHPD)

- Nebraska's General Fund appropriation for substance abuse services has not been substantially increased for more than ten years. Although no comparisons of state funding are available for substance abuse programs, a recent study by the Substance Abuse Task Force showed that since 1992, funding for substance abuse services, adjusted for inflation, has decreased by 16.5% (source: Substance Abuse Task Force Report).

- During FY 1997, Regional Centers funding ranked 23rd nationally based on per capita spending for *institutional* care as reported by NASMHPD. Per capita spending during that year was $25.41compared to the national average of $26.77.

Critical Issues Related to System Financing. Inadequate funding to provide the capacity necessary to meet the needs of mental health and substance abuse consumers is the primary cause for the problems presenting themselves in the mental health and substance abuse system. The system is not able to maintain the service capacities necessary to meet consumer need and level of demand at the funding current level. The financial issues now facing the NBHS are described below.

- An estimated $4,814,312 million shortfall will exist annually beginning FY02 in the mental health and substance abuse system. In FY98-99 approximately $7.5 million was appropriated to the system to address the shortage of service capacity and increase rates. The source of funds initially used to add capacity is no longer available and must be replaced with state general funds if services are to continue at the current capacity. Failure to maintain this commitment will result in an increase in the severity of the current problem. In addition, this problem will be magnified by the federal *Maintenance of Effort* requirements. Federal grants include *Maintenance of Effort* requirements that specify the level of funding that must be maintained in order to receive the full grant amount. The failure to maintain the current funding level (established with the one-time funding appropriated in FY 98-99) may jeopardize Federal Mental Health ($1,727,000+) and Substance Abuse ($7,472,000+) Block Grant funding.

- A deficit will exist for FY 01 as a result of the closure of Paxton Manor in July 2000, an assisted living facility in Omaha. A number of Paxton Manor consumers needed mental health services and were relocated to mental health facilities in Omaha. Because there were no funds to pay for these services the Governor authorized HHSS to fund the services through a deficit request to be made for FY 01. The amount of this deficit will need to be added to future funding appropriations to insure Paxton Manor consumers continue to be served in the community. The ongoing cost of providing these services is expected to be $1,316,160 ($625,175 in State General funds and $690,985 in federal funds.)

- A substantial investment of State General Funds is necessary to provide the service capacities necessary to meet the unmet need for mental health and substance abuse services.

- Increases in State General Funds for Mental Health and Substance Abuse programs will impact the amount of county match required. Regional Governing Boards are required to provide funds for community services. The statute currently requires that one dollar in match will be provided for each three dollars in state General

Funds. Not less than 40 per cent of this match must be in the form of local and county taxes. Counties are now restricted in providing additional tax funds by the county tax lids. If substantial state funds are appropriated to the mental health and substance abuse programs, a strategy for reducing the impact on county budgets must be included.

- In 1995 the Legislature passed LB752, the Rehabilitation and Support Mental Health Services Incentive Act, which authorized the development and implementation of Medicaid Rehabilitation Option services, allowing the public system to access federal funds. The Rehabilitation Option services developed include Community Support, Day Rehabilitation, Psychiatric Residential Rehabilitation and Assertive Community Treatment. The legislative intent was to increase federal participation in a revenue-neutral manner for the purposes of increasing community-based mental health services. It was not the intent of the Legislature to create entitlement. Medicaid and Health Care Finance Administration (HCFA) do not yet approve assertive Community Treatment as a Medicaid Rehabilitation Option service. This service has been paid for with 100% Community Aid general funds. Federal matching funds cannot be claimed until this issue is resolved. Consequently we have not fully maximized Medicaid Rehabilitation Option as a funding source.

- Section 108 of LB 880 (1999) required the implementation of the federal Medicaid substance abuse and alcoholism option in a revenue neutral manner. The Medicaid Division concluded that this could not be accomplished and remains revenue neutral.

- The most effective and cost efficient way for the state to expand substance abuse services is to provide additional state General Funds to support implementation of a Medicaid Rehabilitation Option for adult substance abuse treatment.

- State Excise Taxes on Alcohol and Beverages have not been increased in more than 15 years. Traditionally increases in substance abuse funding have been financed by increases in excise taxes.

RATES PAID FOR SERVICES

The rates paid for providing mental health and substance abuse services have not reflected the increasing costs of doing business. Unlike the nursing home industry and Medicaid, the cost of doing business has not traditionally been included in the HHSS or Governor's budget. Mental health and substance abuse providers must seek legislative appropriations to make rate changes. In the NBHS, increasing rates without specific appropriations to do so results in a reduction in service capacity.

- Rates paid for services are a significant factor in the recruitment and retention of staff for both Regional Centers and community providers. Without a systematic way of

reflecting the cost of doing business in rates paid providers, providers will continue to lose staff and resources to the private sector.

- Housing for the population served by NBHS is severely limited. The rates paid for assisted living services have had a critical impact on the availability of these services for this population. The lack of the facilities results in consumers remaining in Regional Centers and residential facilities even though they may need a lower level of care.

It is important to understand that in NBHS, increasing rates will not increase service capacity.

SYSTEM OPERATIONS

During the last five years there have been a number of operational improvements made to the NBHS system. These include: movement of the substance abuse short-term residential services to the community, implementation of an improved information system, creation of field care management, establishing a fee for service payment system, implementation of authorization of services procedures, utilization management, and improvement of the accountability in financial reimbursement process. However, a number of issues exist that impact the system and must be addressed to allow the continued improvement of NBHS:

Transition between Service Providers. The problems associated with transitioning *discharge ready* Regional Center consumers to the community or transitioning consumers between services in the community can best be addressed by adding community service capacity. Added capacity would allow for the diversion of consumers prior to commitment and shorten the time frame from the point in time when consumers are ready to move to the community and when they actually do make that transition. Regional Center and Regional Administrators agree, however, that increased communication and an improved process for moving consumers to and from the community (care coordination) are critical to ensuring timely movement of consumers through the system of care.

Some consumers are discharged to the community without the knowledge of the community service system. This does not allow for adequate follow-up in the community. For example, when consumers are discharged from Regional Centers, appointments with community providers are sometimes set for a date longer than two or three weeks after the date of discharge. Appointments with community providers should be no later than one week after discharge. The longer the wait period between discharge and an appointment in the community, the greater chance the consumer will return to the Regional Center increases.

There are currently several initiatives underway to improve this process. Each Regional Center is involved in a project with the Regions to improve the effectiveness of this process. The systems management contractor, responsible for the authorization

of services and maintaining the information system for the public system, has placed care managers at the Regional Centers to assist with this process.

The transition of consumers from Regional Centers to community services is one of the critical linkages insuring appropriate and timely care for consumers. A consumer's health and well being depend on this transition. Regional Centers and Regions must improve the linkages between service providers and the processes for moving consumers to appropriate services.

Information System Participation. Providers including Regional Centers do not fully participate in the NBHS information system. Because not all consumer information resides in one place, utilization management and tracking provider accountability and consumer outcomes is very difficult. A new process for collecting and tracking consumer information after discharge from Regional Centers has been put in place with limited success. These efforts must be expanded and closely monitored. All providers in the public system must provide the information necessary to effective management of the system.

Emergency Behavioral Health Services. The lack of capacity in the community has driven the system to focus on involuntary, legal holds. Access to emergency care is severely limited for persons who voluntarily seek treatment. The emphasis on acute hospital inpatient services negates the positive impact of less intensive crisis interventions and is more costly. The current system is public safety-driven rather than consumer need-driven. The decision on emergency holds, by state law, is a law enforcement decision and not necessarily the result of clinical need.

Access to Services. Several issues are important to ensuring that all Nebraskans can access services in a timely manner.

- Some rural providers have closed or are considering closing satellite offices because of the cost of doing business. Small satellite offices do not generate the revenues necessary to cover the cost of doing business. They frequently operate only one or two days a week while having to pay for the costs of maintaining an office. Rural offices also have added costs associated with transportation.

- There is a shortage of psychiatrists, substance abuse counselors, and Licensed Mental Health Practitioners in rural areas making it difficult to provide psychiatric coverage and mental health and substance abuse services to those in need. It is difficult to find qualified professionals who are dually credentialled (mental health and substance abuse) to provide integrated services. There are only 53 dually credentialled individuals in the state. Increasing the number of mental health and substance abuse professionals requires a substantial investment of time and resources.

- The Supreme Court (Olmstead, Commissioner, Georgia Department of Humans Services v. L.C., June 1999) ruled that unnecessary segregation of persons in long-

term care facilities constitutes discrimination under the Americans with Disablities Act that cannot be justified by a lack of funding. This decision clearly supports the principle of providing services in the most integrated setting possible. Individuals who can be served in less-restrictive environments should be able to access these services in a timely manner. In order for this to occur it is important that a reasonable amount of community-based services are planned for and funded.

Performance Management. The system does not currently have adequate means to measure outcomes. A method for measuring system performance is currently being developed as part of the NBHS strategic planning process. This process should continue with the involvement of the Regional Centers in the development of performance measures. The system has several quality improvement initiatives underway. These need to be integrated to reflect the system processes as a whole.

Availability of Human Resources. Community-based providers, Regional Centers, and Regional offices have difficulty recruiting and retaining staff. The turnover rate for the Regional Centers in FY 1999 was 15 per cent. Nearly ten per cent of Regional Center positions remain unfilled because of the difficulty of attracting workers. The tight labor market in Nebraska results in intense competition for the limited number of qualified applicants.

Commitment of Individuals under the Mental Health Commitment Act. There appears to be inconsistency in the commitment of individuals under the Mental Health Commitment Act. There is a threefold difference in the commitment rates for the state's Mental Health Boards. Monthly inpatient commitment rates for the six regions ranged from 1.5 per hundred thousand to 4.9 per hundred thousand during FY 2000.

POPULATION SERVED

The impact of the changes in Nebraska's population and how it is dispersed throughout the state, together with the changing needs of the consumers now requesting services from the NBHS will continue to impact the effective delivery of services.

- The increased number of sex offenders being served by the Regional Centers as a result of the Supreme Court decision in Henricks v State of Kansas has reduced the capacity for inpatient care available to persons with a mental illness. As of November 30, 2000, 22 sex offenders were occupying Regional Center beds and it is expected that an additional 20 to 30 offenders per year will be committed to Regional Centers

- The population of the state continues to shift to urban areas, negatively impacting accessibility in rural areas and increasing demand for services in urban areas.

- Rural consumers sent for residential treatment services outside of their region often experience difficulties related to geographical distance and extended separation from family support systems.

- The demand for rural/farm crisis counseling has increased by 150 per cent based on current requests for the service.

- The average life span of Americans continues to increase. The older population has the same mental health and substance abuse issues as the rest of the population. How those issues present themselves are often very different and may be difficult to detect. Specialized assessment and treatment are required.

- The population of Nebraska continues to become more diverse. The minority population is generally under served by the mental health and substance abuse system. A number of barriers exist that keep ethnic and racial minority groups from seeking treatment.

- The percent of mentally ill consumers identified as having co-existing substance abuse problem has increased. In Region V, for example, the per cent of persons in need of mental health and substance abuse treatment as reported by the Region V Crisis Center has increased from 28 per cent in 1991, to 52 per cent in 1999.

- An increasing number of individuals are being recognized as having substance abuse problems within specific populations and are being referred for treatment. (Criminal Justice, Welfare to Work, and Deaf and Hard of Hearing)

- The stigma associated with mental disorders and substance abuse problems has existed throughout history. Where a person lives, how they are employed, whom they associate with are all impacted by this stigma. Although efforts to educate the general public have resulted in greater knowledge of mental illness and substance abuse it has not allayed the fear, bias, and prejudices associated with mental disorders and substance abuse problems (Mental Health: A Report of the Surgeon General)

A significant factor impacting post commitment days and lengths of stay at the Regional Centers is the increase in the commitment of sex offenders, and substance abuse consumers. With the Regional Centers traditionally providing acute inpatient and secure residential mental health services, these commitments reduce the number of beds available at the Regional Centers for individuals with mental illness. Sex offenders can be expected to have extensive lengths of stay, which essentially eliminates the bed they occupy from being considered as capacity for individuals needing acute or secure services. The commitment of these individuals also impacts the types of services offered by the Regional Centers.

The shift of population to the urban centers will challenge the system in that it must continue to provide timely access to persons who live in rural areas. The need for individualized services will also increase as the system becomes more cognizant of age,

race, and culture. The flexibility to adapt to these changes is essential to effectively managing the system.

CONCLUSION

The backlog of consumers unable to transition from Regional Centers into community services, the increase in post commitment days, and the delay in the placement of consumers in appropriate levels of care (long waiting lists) are a result of inadequate capacity to treat mental health and substance abuse consumers. Without the funding to provide adequate capacity for mental health and substance abuse services the state can expect the following:

- Post commitment days will increase, resulting in increased costs to the public system. Demands on the Legislature to pay for these services will increase.

- Public safety will be at greater risk because mental health and substance abuse consumers will not have access to services when needed.

- Appropriate services to meet the increased demand of the criminal justice system will not be available. The Legislature will be pressured to increase funding to provide treatment for criminal justice system clients.

- Increased health care costs. The impact on the health care system of the failure to treat mental health and substance abuse consumers has been documented. The cost of health care and health care insurance can be expected to increase.

- The NBHS system will be at risk of noncompliance with the Olmstead decision. It will difficult to comply with the goal of moving consumers to less restrictive community environments in a timely manner.

- Increased length-of-stays, beyond necessity, will not result in good clinical outcomes for the consumer and will compromise the effectiveness and efficiency of services.

The current process of implementing short-term solutions as crises occur, i.e. appropriations to pay for emergency inpatient days in Region VI and deficit funding to pay for Paxton Manor closure, will continue to exacerbate the problems which now exist. Any effective solution must include the funding of additional capacity for services that divert consumers from these more restrictive and expensive solutions.

RECOMMENDATIONS

Substantial progress and improvements have been made to NBHS in the last five years to redesign the service system to be more effective and efficient. More effective management of financial resources has benefited the system, however, future improvements to meet unmet need and increased demands must include additional funding.

For the system to address the needs and issues identified in this document, the following recommendations are made:

1. Increase Funding for Mental Health and Substance Abuse Service Capacity

a. The Legislature must appropriate additional state general funds to fund the shortfall of $4,814,312 ($2,546,949 mental health; $2,267,363 substance abuse) beginning in FY 02. This will ensure services currently being provided in the community will continue.

b. The Legislature must appropriate funds for the deficit request of $ 1,316,160 ($625,175 state general; $690,985 federal) to pay for the services provided to former Paxton Manor residents in FY 02. Paxton Manor residents are expected to continue to need services into the future. This funding will ensure capacity continues to exist.

c. The Legislature should increase state General Funds appropriated to the public mental health and substance abuse system consistent with the tables below.

MENTAL HEALTH – PROGRAM 366				
YEAR	**COMMUNITY SVCS.**	**TRIBAL SERVICES**	**OTHER SVCS.**	**TOTAL**
FY 02	$10,000,000	$102,504	$116,135	$10,219,439
FY 03	$10,000,000	$102,504	$116,135	$10,219,439
FY 04	$5,000,000	$51,251	$58,467	$5,109,720
FY 05	$5,000,000	$51,251	$51,251	$5,109,720

SUBSTANCE ABUSE – PROGRAM 034				
YEAR	**COMMUNITY SVCS.**	**TRIBAL SERVICES**	**OTHER SVCS.**	**TOTAL**
FY 02	$10,000,000	$360,595	$324,880	$10,685,475
FY 03	$10,000,000	$360,595	$324,880	$10,685,475
FY 04	$5,000,000	$180,298	$163,440	$5,342,737
FY 05	$5,000,000	$180,298	$163,440	$5,342,737

Initial priorities for funding should be targeted at:

- Decreasing the number of post commitment days,
- Decreasing the number of EPC's (Emergency Protective Custody),
- Decreasing the number of days at inappropriate levels of care,
- Decreasing the number of commitments to Regional Centers for Substance Abuse,
- Increasing the service capacity available to special populations including individuals in the criminal justice system, and
- Increasing the service capacity available to Native Americans.

The following strategies should be considered when developing service capacity:

- Ensure that funding increases annually over a four-year period. The availability of the mental health and substance abuse professional human resources available limits the number of services that can be developed in a given year.
- Fund the lowest cost services first (i.e., Community Support). This will facilitate the transition of consumers in higher intensity services to appropriate levels of care and ensure increased continuity of care.

In response to these proposed priorities and strategies the Regions have developed regional funding plans described in Attachment 2.

d. The Legislature should increase the funding made available to tribes commensurate with Regional funding on an annual basis. Tribes are also experiencing shortages in the availability of mental health and substance abuse services. (This is reflected in the funding tables in number c above.)

e. The Legislature should adopt a method for reducing the impact of statutory county match requirements.

f. The Legislature should provide for Medicaid coverage of Substance Abuse services. This strategy should be adopted consistent with the MRO legislation passed in 1995. The legislation allowed for federal matching funds to be retained in the NBHS public system to expand service capacity. It also required that these services be provided in a revenue neutral manner with state funds. (See Attachment 3).

g. HHSS approve proposed regulations for Assertive Community Action (ACT) teams and HCFA approve the state plan including ACT. As a result this would allow the claiming of federal matching funds to be used to expand services.

h. HHSS review the Medicaid Division's draft plan for increasing rates for Assisted Living support services. (See Attachment 4.)

i. NBHS develop and implement a strategy for ensuring that mental health and substance abuse services are available in rural areas.

j. Adopt a method for the Legislature to periodically review the funding of the mental health and substance abuse system to ensure service capacity is appropriate to the changes in the state's population.

k. HHSS and the Governor support the recommendations and funding requests (including an alcohol tax increase) of the Substance Abuse/Criminal Justice Task Force.

l. HHSS and the Legislature provide funding and change eligibility requirements to enable access to the Indigent Medications funds for persons without being required to be in a Regional Center or committed.

2. Increase Rates

a. The Legislature should provide for rate increases as part of the funding requested in the previous section. The HHSS and NBHS review the current cost of doing business and increase rates as necessary, but not more than 5% in FY 2002, to account for increases in business expenses incurred in delivering mental health and substance abuse services.

b. The Legislature should require that HHSS and NBHS develop an ongoing process (i.e., biennial review) for reviewing and revising rates consistent with the cost of doing business.

c. The Legislature should revise the Regional Center budget to reflect changes in the cost of doing business.

3. Continue To Improve the Operations of the NBHS

a. NBHS must identify the processes critical to moving consumers between providers (including the Regional Centers) and establish appropriate quality teams to improve communication and performance.

b. NBHS must develop the measures critical to monitoring the success of the NBHS. The following list of measures or indicators should be considered for monitoring the success of resolving the issues described in this report:
   - Number of post commitment days,
   - Number of individuals on Wait lists,
   - Access to crisis beds by voluntary consumers,
   - Number of days consumers are in inappropriate levels of care,
   - Lengths of stay at acute and secure levels of care at Regional Centers and private inpatient hospitals,
   - Readmission rates to Regional Centers at 30 and 180 days,
   - Number of consumers seen within 7 days of discharge from Regional Center,

- Number of commitments to Regional Centers,
- Number of commitments by Region, Regional Center, levels of care, and diagnoses, and
- Number of persons in criminal justice system served in mental health and substance abuse services.

c. HHSS must require all providers in the NBHS and Regional Centers to participate fully in the NBHS data information system to facilitate outcome measurement and systems communication.

d. HHSS should continue the development of capacity to serve sex offenders at the Lincoln Regional Center. In addition, HHSS should review the future capacity needs for these services and develop a plan for creating the necessary capacity at all Regional Centers.

e. NBHS should review and adjust current services being delivered to Nebraskans to reflect the need for cultural and gender competency, serving older Nebraskans, and a growing ethnic and minority population.

f. HHSS should review the organization of the Regional Centers. The current separation of staff by agency (HHSS/Services vs. HHSS/Finance and Support) and organization by function impedes effective management of these facilities.

g. NBHS should expand state-funded prevention services to include both mental health and substance abuse prevention services.

h. HHSS should collaborate with the Department of Economic Development to address the housing and homelessness issues. Expand the availability of housing options for persons with severe and persistent mental illness and substance abuse/dependency.

i. HHSS and NBHS should review the need for acute inpatient hospital mental health capacity in western Nebraska to determine if it is appropriate to establish this capacity closer to the consumer's support system. (See Attachment 5.)

j. NBHS should report annually to the Legislature and Governor on the success of resolving the problems identified in this document.

k. NBHS should expand the education and training opportunities for systems and direct care staff.

l. NBHS should establish and require all providers (including Regional Centers) to meet uniform, consistent system defined quality standards.

4. Impact of the Recommendations

The recommendations made will not solve all problems identified in this report. However over time they will result in a more effective and efficient system. The following results are expected:

- Treating consumers at appropriate and lower levels of care results in more effective treatment and better use of funds,
- More consumers can be served at lower levels of care, resulting in lower costs per persons served.
- With full participation of providers in the information system, better data will be available to be used to determine service needs, manage the system, and project future funding requirements.
- Expansion of Medicaid funding will increase federal participation, increase the availability of services, and reduce cost shifting.
- The development of new services will better meet the changing needs of consumers.
- Better coordination of services between providers will increase consumers movement through services, reduces costs, and improves consumer chances for recovery.
- Timely transition of consumers to appropriate community services assists in meeting the requirements of the Olmstead decision.
- For every one-dollar spent on the treatment of offenders in substance abuse and mental health services, four to seven dollars are saved in the reduced cost to the criminal justice system.

NEXT STEPS

The recommendations made in the previous section are extensive and can be expected to take both time and a significant amount of resources to fully adopt. Several immediate actions are necessary to address the current crises and sustain the current level of services in the mental health and substance abuse system. The following actions should be taken immediately:

1. **Appropriation by the Legislature for mental health and substance abuse services.** Increases should be made as described in the following tables:

MENTAL HEALTH – PROGRAM 366			
YEAR	GENERAL FUNDS*	FEDERAL FUNDS**	TOTAL FUNDING
CURRENT FY 01	$18,933,411	$9,584,930	$28,518,341
FY 2001 – 2002	$32,324,974	$8,959,755	$41,284,729
FY 2002 – 2003	$42,544,413	$8,959,755	$51,504,168
FY 2003 – 2004	$47,763,852	$8,959,755	$56,723,607
FY 2004 – 2005	$52,983,291	$8,959,755	$61,943,046

** State Funds: adds $2,546,949 for mental health shortfall; adds $625,125 Paxton.*
*** Federal Funds: Decrease SA $2,267,363 shortfall; adds $690,985 Paxton.*

SUBSTANCE ABUSE – PROGRAM 034				
YEAR	GENERAL FUNDS*	CASH FUNDS	FEDERAL FUNDS	TOTAL FUNDING
CURRENT FY 01	$5,521,139	$1,354,507	$7,453,873	$14,329,519
FY 2001 – 2002	$16,206,614	$1,354,507	$7,453,873	$25,014,994
FY 2002 – 2003	$26,892,089	$1,354,507	$7,453,873	$35,700,469
FY 2003 – 2004	$32,234,826	$1,354,507	$7,453,873	$41,043,206
FY 2004 – 2005	$37,577,563	$1,354,507	$7,453,873	$46,385,943

***State Funds: adds $2,267,363 for substance abuse shortfall.*

These increases will:

a. Provide $4,814,312 annually in general funds necessary to maintain the current level of both mental health and substance abuse services. The one-time funding in FY98 made no plans for the sustainability of funding services in the future. These funds currently support: Community Short Term Residential Substance Abuse services and Non Medicaid eligible consumers in Psychiatric Residential Rehabilitation, Day Rehab, Community, and the Region VI Assertive Community Treatment services

b. Provide ongoing funding for services to former Paxton residents in the amount of $1,316,160.

c. Provide $30,658,318 for funding community mental health capacity increases over a four-year period

c. Provide $32,056,424 for funding substance abuse capacity increases over a four-year period

d. Provide for rate increases as determined by the HHSS working with the Regions and providers to study the costs of doing business. Rate increases should not exceed five per cent in any one year. The funding required to increase rates is included in the amounts shown in the table above.

2. **The Legislature requires that HHSS and NBHS develop a method for Recommending Rate Increases.** A review of the cost of providing services should be performed biennially. The method should include the impact of inflation and set reimbursement rates for the NBHS that will cover the cost of doing business. HHSS will also provide an estimate of the budgetary impact of such rate increases. This will allow the Legislature to make informed decisions regarding rate increase funding.

3. The NBHS continue to make system improvements. The NBHS should review the recommendations made in this report and establish priorities for making improvements to the system.

Initial efforts must include the strategies that will have the greatest impact on addressing the current crises within the system. These include:

- Improvement in the process of transitioning consumers to and from the Regional Center to the community.
- Increase the capacity at the Regional Centers for treatment of sex offenders and develop a plan for how the future need for this service will be addressed.
- Establish quality, affordable housing for individuals with mental illness or substance abuse problems.
- Review the current service delivery system for its ability to address current and future needs of consumers.

NBHS must also continue its long-term efforts to improve the quality of the services delivered. The following strategies should be used:

- Continue to develop and implement a strategic plan. This process should include the identification of consumer need and level of demand, the development of Key Success Factors (indicators that measure the success of the system in accomplishing its mission and vision,) and the ongoing measurement of those factors.
- Fully implement a quality improvement process. This process should include the identification of critical processes that impact performance of the system

and the establishment performance improvement projects to improve system effectiveness.

ATTACHMENT 1

The Nebraska Behavioral Health System (NBHS)

THE NEBRASKA BEHAVIORAL HEALTH SYSTEM (NBHS)

The State of Nebraska, in cooperation with Regional Governing Boards, provides behavioral health (BH) services through six Regional networks and three Regional Centers. Each of the Regions is organized under the State's Interlocal Cooperation Act as provided by the Community Mental Health Services Act (Neb. Rev. Stat. SS71-5001 to 71-5014) and the Alcoholism, Drug Abuse, and Addiction Services Act (SS71-5016 to 71-5041.) Regions contract with local providers to deliver BH services. The Regional Centers are 24-hour facilities operated by the State's Department of Health and Human Services.

1. **Health and Human Services System.** The State of Nebraska's Health and Human Services System consists of three State agencies: Health and Human Services, HHS Finance and Support, and HHS Regulation and Licensure. The HHS System is governed by a Policy Cabinet appointed by the Governor. The Cabinet consists of the directors of the three agencies, the Chief Medical Officer, and a Policy Secretary. The Policy Secretary chairs the Cabinet and an advisory body known as the Partnership Council.

   HHS through the Division of Mental Health, Substance Abuse, and Addiction Services, is responsible for leadership, planning, coordination, administration, regulation, and monitoring of the behavioral health system in Nebraska. HHS contracts with Regional Governing Boards to deliver or contract for the delivery of services in their geographical Region. HHS is also a direct service provider of public inpatient behavioral health services through three State psychiatric hospitals (Hastings, Lincoln, and Norfolk Regional Centers).

2. **Regional Governing Boards.** The community based Mental Health and Substance Abuse (MH/SA) Regions were established by dividing the State into six geographic service areas. Each of the State's 93 counties is designated as a member of one Region. Each Region is a subdivision of local government, directed by a Regional Governing Board (RGB) composed of one county commissioner from each of the counties represented in the Region. Regional Governing Boards (RGB) are responsible for governing and supervising the delivery of MH/SA services within their Region.

Each Region is responsible for developing annual service plans detailing expected expenditures and anticipated levels of services and revenue. Based on the annual plan and expected expenditures an annual contract is established between the Department and each Region outlining the services to be provided and federal and state requirements on the use of funds. RGB's establish the service network for each Region and enter into contracts with public or private service agencies or individuals or assume the responsibility themselves to deliver MH/SA services for the Region.

A Regional Program Administrator (RPA) is appointed by the RGB to serve as the chief executive officer responsible to the Board. The RPA is responsible for coordination, program planning, financial, and contract management and the evaluation of all MH/SA services funded through the RGB.

MISSION

The mission of the NBHS is:

To organize and provide for
an effective and efficient system
of quality Behavioral Health Services
for the people of Nebraska

VISION

The vision of the NBHS is:

Working together in partnership
for a united and comprehensive
Behavioral Health System
driven by consumer needs

VALUES

The NBHS will operate consistent with the following values:

THE SYSTEM IS CONSUMER DRIVEN

- Consumer and Family Involvement at all Levels
- Consumers Treated with Dignity and Respect
- Easy Consumer Access

THE SYSTEM PROVIDES FOR ACCESS TO NEEDED SERVICES

- Limited Resources targeted to Those Most in Need
- Assured Access to Behavioral Health Services
- Effective Prevention

THE SYSTEM IS FOCUSED ON CONSUMER OUTCOMES

- Proven Efficacy
- Least Restrictive
- Improved Functioning
- Decreased Symptoms
- High Customer Satisfaction

STRENGTH-BASED SERVICES

- On-going Assessment
- Optimal Level of Individual Functioning
- Wellness and Recovery Focused

COMPETENT STAFF

- Culturally and Gender Sensitive
- Demonstrated Competence
- Trained in Best Practices

THE SYSTEM UTILIZES CONTINUOUS IMPROVEMENT

- Measured Against High, Local, and National Standards
- Accurate and Meaningful Data

ATTACHMENT 2

Regional Funding Priorities

REGIONAL FUNDING PRIORITIES

The six mental health and substance abuse Regions were asked to project how additional funds which might be appropriated to the NBHS would be used to address the system's most pressing issues. The Regions were asked to target the following priorities when planning for expanded service capacity:

- Decreasing the number of post commitment days
- Decreasing the number of EPC's (Emergency Protective Custody)
- Decreasing the number of days consumers are served in inappropriate levels of care
- Decreasing the number of commitments to Regional Centers for Substance Abuse
- Increasing the service capacity available to special populations including the individuals in the criminal justice system, and

Regions were also asked to incorporate a strategy of funding the lowest cost services first to facilitate the transition of consumers in higher intensity services to appropriate levels of care.

The financial plans submitted by the Regions and a statewide total of those plans are contained in the tables, which follow.

REGION I

MENTAL HEALTH			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Day Treatment			-						
Non-	Intensive Outpatient									
Residential	Day Rehabilitation									
Services	Outpatient									
	Med. Management			72,349		72,349				
	Psych. Testing									
	Vocational Support									
	Day Support									
Residential	Secure Residential			175,000		175,000				
Services	Intermediate Res.									
	Psych. Res. Rehab.									
Cornerstone	Emergency*			161,249		161,249				
	Community Support			67,853		67,853				
	ACT									
	Prevention									
Other*										
TOTAL ADULT			-	476,451	-	476,451	-	-	-	-
CHILDREN	Pro Partner - MH									
Services	Day Treatment - MH									
	Home-Based - MH									
	Respite Care - MH									
	Ther. Cons. - MH									
	Outpatient - MH									
	Med. Mgmt - MH									
	Intensive OP - MH									
	Youth Assess. - MH									
	Other									
TOTAL CHILDREN			-	-	-	-	-	-	-	-
RATE INCREASE										
ADMINISTRATION										
TOTAL MENTAL HEALTH			-	476,451	-	476,451	-	-	-	-

REGION I

SUBSTANCE ABUSE			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Partial Care									
Non-	Intensive Outpatient									
Residential	Outpatient									
Services	Med. Management									
Residential	Intermediate Res.									
Services	Dual Disorder Res.			188,340		188,340				
	Short Term Res.									
	Therapeutic Comm.									
	Halfway House									
Cornerstone	Emergency*									
	Community Support									
	Prevention									
	Other (Women+Flex)									
	Prevention									
TOTAL ADULT			-	188,340	-	188,340	-	-	-	-
CHILDREN	Ther. Comm. - SA									
Services	Partial Care - SA									
	Halfway House - SA									
	Outpatient - SA									
	Intensive OP - SA									
	Youth Assess. - SA									
	Comm. Support - SA									
Other*										
TOTAL CHILDREN			-	-	-	-	-	-	-	-
RATE INCREASE										
ADMINISTRATION										
TOTAL SUBSTANCE ABUSE			-	188,340	-	188,340	-	-	-	-
TOTAL ALLOCATION			-	664,791	-	664,791	-	-	-	-

REGION II

MENTAL HEALTH			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Day Treatment			-						
Non-	Intensive Outpatient			168,800		67,520		23,630		31,180
Residential	Day Rehabilitation			46,997		39,031		36,918		26,068
Services	Outpatient			5,073		104,495		27,867		18,391
	Med. Management			1,765		30,288		2,987		5,631
	Psych. Testing			-		-		28,000		1,860
	Vocational Support									
	Day Support			12,000		30,000		2,340		4,820
Residential	Secure Residential									
Services	Intermediate Res.									
	Psych. Res. Rehab.									
Cornerstone	Emergency*			14,882		16,160		124,278		122,138
	Community Support			216,173		116,173		16,456		33,899
	ACT									
	Prevention							32,474		10,848
Other*				9,000		5,000		4,000		2,160
TOTAL ADULT			-	474,690	-	408,667	-	298,950	-	256,995
CHILDREN	Pro Partner - MH			228,800		99,500		-		27,858
Services	Day Treatment - MH									
	Home-Based - MH									
	Respite Care - MH									
	Ther. Cons. - MH									
	Outpatient - MH			164,750		42,508		3,217		12,629
	Med. Mgmt - MH			64,320		19,280		2,508		5,166
	Intensive OP - MH			80,600		25,900		3,195		6,582
	Youth Assess. - MH			-		15,000		900		1,854
	Other									1,080
TOTAL CHILDREN			-	538,470	-	202,188	-	9,820	-	55,169
RATE INCREASE										
ADMINISTRATION				16,731		18,892		6,103		12,789
TOTAL MENTAL HEALTH			-	1,029,891	-	629,747	-	314,873	-	324,953

REGION II

SUBSTANCE ABUSE			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Partial Care									
Non-	Intensive Outpatient					219,000		6,570		13,353
Residential	Outpatient			5,570		5,737		5,909		12,173
Services	Med. Management					36,000				2,160
Residential	Intermediate Res.									
Services	Dual Disorder Res.									
	Short Term Res.			218,999		13,140		43,899		29,701
	Therapeutic Comm.									
	Halfway House									
Cornerstone	Emergency*			10,452		28,509		48,809		14,041
	Community Support			4,500		22,000		2,385		4,913
	Prevention			7,302		7,521		7,747		39,551
	Other (Women+Flex)			3,000		22,000		12,000		7,440
	Prevention									
TOTAL ADULT			-	249,823	-	353,907	-	127,319	-	123,332
CHILDREN	Ther. Comm. - SA									
Services	Partial Care - SA									
	Halfway House - SA									
	Outpatient - SA			64,850		63,780		58,270		11,241
	Intensive OP - SA			58,640		77,900		70,260		12,408
	Youth Assess. - SA			41,157		28,343		4,150		4,419
	Comm. Support - SA			220,000		110,000		50,500		22,830
Other*										
TOTAL CHILDREN			-	384,647	-	280,023	-	183,180	-	50,898
RATE INCREASE										
ADMINISTRATION				19,061		19,606		9,603		2,348
TOTAL SUBSTANCE ABUSE			-	653,531	-	653,536	-	320,102	-	176,578
TOTAL ALLOCATION			-	1,683,422	-	1,283,283	-	634,975	-	501,531

REGION III

MENTAL HEALTH

			2002		2003		2004		2005	
			ADDITIONAL		ADDITIONAL		ADDITIONAL		ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Day Treatment	159								
Non-	Intensive Outpatient									
Residential	Day Rehabilitation	44		84,222		44,000				88,000
Services	Outpatient					60,000				60,000
	Med. Management					35,000				
	Psych. Testing					15,000				
	Vocational Support	42				40,000				
	Day Support					30,000				
Residential	Secure Residential	187								
Services	Intermediate Res.	157				220,329		613,251		295,830
	Psych. Res. Rehab.	90								
Cornerstone	Emergency*			95,000		90,000				-
	Community Support	228		54,207		55,000				-
	ACT	36								
	Prevention									
Other*				30,000		111,549				96,000
TOTAL ADULT			-	263,429	-	700,878	-	613,251	-	539,830
CHILDREN	Pro Partner - MH			156,000		156,000				-
Services	Day Treatment - MH									
	Home-Based - MH			95,000		95,000				-
	Respite Care - MH									
	Ther. Cons. - MH									
	Outpatient - MH									
	Med. Mgmt - MH									
	Intensive OP - MH									
	Youth Assess. - MH									
	Other			397,000		274,575				73,421
TOTAL CHILDREN			-	648,000	-	525,575	-	-	-	73,421
RATE INCREASE				29,800		40,000		20,000		20,000
ADMINISTRATION				49,530		66,650		33,300		33,300
TOTAL MENTAL HEALTH			-	990,759	-	1,333,103	-	666,551	-	666,551

REGION III

SUBSTANCE ABUSE			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Partial Care	59								
Non-	Intensive Outpatient	22		44,916		44,916		30,000		
Residential	Outpatient			82,708		120,000		60,000		
Services	Med. Management									
Residential	Intermediate Res.	24				174,997		483,420		
Services	Dual Disorder Res.	172								391,711
	Short Term Res.	150		466,000		329,778				
	Therapeutic Comm.	111		139,974		139,974				
	Halfway House	51		150,000		100,000				
Cornerstone	Emergency*			100,000		100,000		50,000		
	Community Support	187				36,000				
	Prevention									
	Other (Women+Flex)					62,000				
	Prevention			107,132		107,132				
TOTAL ADULT			-	1,090,730	-	1,214,797	-	623,420	-	391,711
CHILDREN	Ther. Comm. - SA					20,000				
Services	Partial Care - SA									
	Halfway House - SA			162,067		38,000				
	Outpatient - SA									
	Intensive OP - SA									
	Youth Assess. - SA									
	Comm. Support - SA									
Other*				20,000						
TOTAL CHILDREN			-	182,067	-	58,000	-	-	-	-
RATE INCREASE				41,505		41,505		20,400		13,000
ADMINISTRATION				69,170		69,170		33,800		21,300
TOTAL SUBSTANCE ABUSE			-	1,383,472	-	1,383,472	-	677,620	-	426,011
TOTAL ALLOCATION			-	2,374,231	-	2,716,575	-	1,344,171	-	1,092,562

REGION IV

MENTAL HEALTH			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Day Treatment									
Non-	Intensive Outpatient									
Residential	Day Rehabilitation							334,572		
Services	Outpatient									
	Med. Management									
	Psych. Testing									
	Vocational Support							47,880		
	Day Support									
Residential	Secure Residential									
Services	Intermediate Res.			454,356		225,648				59,618
	Psych. Res. Rehab.					328,500				
Cornerstone	Emergency*			221,550						
	Community Support			218,880		164,160				109,440
	ACT									
	Prevention									50,000
Other*				225,000				33,100		210,000
TOTAL ADULT			-	1,119,786	-	718,308	-	415,552	-	429,058
CHILDREN	Pro Partner - MH					390,000				
Services	Day Treatment - MH									
	Home-Based - MH									
	Respite Care - MH							33,100		
	Ther. Cons. - MH									
	Outpatient - MH									
	Med. Mgmt - MH									
	Intensive OP - MH									
	Youth Assess. - MH									
	Other									
TOTAL CHILDREN			-	-	-	390,000	-	33,100	-	-
RATE INCREASE				81,499		132,630		171,817		191,411
ADMINISTRATION				63,226		65,313		32,656		32,656
TOTAL MENTAL HEALTH			-	1,264,511	-	1,306,251	-	653,125	-	653,125

REGION IV

SUBSTANCE ABUSE			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Partial Care									
Non-	Intensive Outpatient									
Residential	Outpatient									
Services	Med. Management									
Residential	Intermediate Res.									
Services	Dual Disorder Res.			605,607						293,815
	Short Term Res.			109,500	-	438,000				
	Therapeutic Comm.					404,057				
	Halfway House			225,699						
Cornerstone	Emergency*			37,960	-	37,960				
	Community Support			224,400		224,400				
	Prevention									
	Other (Women+Flex)									
	Prevention			50,000	-	100,000				
TOTAL ADULT			-	1,253,166	-	1,204,417	-	-	-	293,815
CHILDREN	Ther. Comm. - SA									
Services	Partial Care - SA									
	Halfway House - SA									
	Outpatient - SA									
	Intensive OP - SA									
	Youth Assess. - SA									
	Comm. Support - SA									
Other*								492,750		492,750
TOTAL CHILDREN			-	-	-	-	-	492,750	-	492,750
RATE INCREASE				35,199		83,408		138,022		143,995
ADMINISTRATION				67,780		67,780		33,199		48,977
TOTAL SUBSTANCE ABUSE			-	1,356,145	-	1,355,605	-	663,971	-	979,537
TOTAL ALLOCATION			-	2,620,656	-	2,661,856	-	1,317,096	-	1,632,662

REGION V

MENTAL HEALTH			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Day Treatment			195,000						
Non-	Intensive Outpatient									
Residential	Day Rehabilitation							319,000		
Services	Outpatient			300,000				86,000		86,680
	Med. Management					160,310				
	Psych. Testing									
	Vocational Support							65,000		
	Day Support									55,000
Residential	Secure Residential									
Services	Intermediate Res.									
	Psych. Res. Rehab.					451,530				
Cornerstone	Emergency*					479,631		256,000		250,000
	Community Support			410,400		164,160				218,880
	ACT			294,600		184,000				
	Prevention			300,000		178,620		100,000		100,000
Other*				500,000						109,440
TOTAL ADULT			-	2,000,000	-	1,618,251	-	826,000	-	820,000
CHILDREN	Pro Partner - MH			550,000		184,000		184,000		
Services	Day Treatment - MH					125,575				
	Home-Based - MH							53,000		
	Respite Care - MH									76,700
	Ther. Cons. - MH									42,000
	Outpatient - MH			150,000						
	Med. Mgmt - MH									
	Intensive OP - MH					55,000				
	Youth Assess. - MH									71,300
	Other					235,425		53,000		100,000
TOTAL CHILDREN			-	700,000	-	600,000	-	290,000	-	290,000
RATE INCREASE										
ADMINISTRATION				231,276		231,276		89,075		89,075
TOTAL MENTAL HEALTH			-	2,931,276	-	2,449,527	-	1,205,075	-	1,199,075

REGION V

SUBSTANCE ABUSE			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Partial Care							190,000		
Non-	Intensive Outpatient					34,870				
Residential	Outpatient			137,744						
Services	Med. Management									
Residential	Intermediate Res.			210,240						
Services	Dual Disorder Res.			452,016		376,680				
	Short Term Res.			400,000		328,500				
	Therapeutic Comm.							300,000		330,000
	Halfway House					127,750				
Cornerstone	Emergency*			300,000		355,000		60,000		115,000
	Community Support					112,200				
	Prevention									
	Other (Women+Flex)									
	Prevention			300,000		355,000		170,000		115,000
TOTAL ADULT			-	1,800,000	-	1,690,000	-	720,000	-	560,000
CHILDREN	Ther. Comm. - SA			135,320		610,000				
Services	Partial Care - SA			76,700						
	Halfway House - SA							230,000		
	Outpatient - SA			130,900						35,000
	Intensive OP - SA			157,080						
	Youth Assess. - SA									75,000
	Comm. Support - SA									100,000
Other*								180,000		
TOTAL CHILDREN			-	500,000	-	610,000	-	410,000	-	210,000
RATE INCREASE										
ADMINISTRATION				188,761		210,868		88,985		69,990
TOTAL SUBSTANCE ABUSE			-	2,488,761	-	2,510,868	-	1,218,985	-	839,990
TOTAL ALLOCATION			-	5,420,037	-	4,960,395	-	2,424,060	-	2,039,065

REGION VI

MENTAL HEALTH

LOC	SERVICE	$	2002 ADDITIONAL CAP.	2002 ADDITIONAL COST	2003 ADDITIONAL CAP.	2003 ADDITIONAL COST	2004 ADDITIONAL CAP.	2004 ADDITIONAL COST	2005 ADDITIONAL CAP.	2005 ADDITIONAL COST
ADULT	Day Treatment									
Non-	Intensive Outpatient									
Residential	Day Rehabilitation					300,000				766,500
Services	Outpatient			200,000		250,000		137,500		250,000
	Med. Management									
	Psych. Testing									
	Vocational Support									
	Day Support									
Residential	Secure Residential									
Services	Intermediate Res.									
	Psych. Res. Rehab.			810,968		810,968		766,500		
Cornerstone	Emergency*			1,625,923		1,455,911		95,067		50,000
	Community Support			176,904		238,285		231,600		156,200
	ACT					50,000				
	Prevention									
Other*										
TOTAL ADULT			-	2,813,795	-	3,105,164	-	1,230,667	-	1,222,700
CHILDREN	Pro Partner - MH					159,120		104,000		52,000
Services	Day Treatment - MH									
	Home-Based - MH									
	Respite Care - MH			25,000		15,000				
	Ther. Cons. - MH									
	Outpatient - MH									
	Med. Mgmt - MH									
	Intensive OP - MH									
	Youth Assess. - MH									
	Other									
TOTAL CHILDREN			-	25,000	-	174,120	-	104,000	-	52,000
RATE INCREASE				383,390		496,668		553,308		609,947
ADMINISTRATION										
TOTAL MENTAL HEALTH			-	3,222,185	-	3,775,952	-	1,887,975	-	1,884,647

REGION VI

SUBSTANCE ABUSE			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Partial Care									
Non-	Intensive Outpatient			90,000		100,000		50,000		50,000
Residential	Outpatient			125,000		300,000		150,000		200,000
Services	Med. Management			250,000						
Residential	Intermediate Res.			65,000		1,069,000				120,000
Services	Dual Disorder Res.					1,600,000		400,000		400,000
	Short Term Res.			584,000						
	Therapeutic Comm.			100,000						
	Halfway House			449,500						
Cornerstone	Emergency*			500,000		400,000		270,000		
	Community Support			160,000		56,100		51,600		561,982
	Prevention									
	Other (Women+Flex)			883,600				473,634		105,672
	Prevention			429,898				100,000		
TOTAL ADULT			-	3,636,998	-	3,525,100	-	1,495,234	-	1,437,654
CHILDREN	Ther. Comm. - SA									
Services	Partial Care - SA									
	Halfway House - SA									
	Outpatient - SA									
	Intensive OP - SA									
	Youth Assess. - SA									
	Comm. Support - SA									
Other*										
TOTAL CHILDREN			-	-	-	-	-	-	-	-
RATE INCREASE				231,622		342,042		374,090		431,670
ADMINISTRATION				50,000		50,000		50,000		50,000
TOTAL SUBSTANCE ABUSE			-	3,918,620	-	3,917,142	-	1,919,324	-	1,919,324
TOTAL ALLOCATION			-	7,140,805	-	7,693,094	-	3,807,299	-	3,803,971

REGIONAL FUNDING PRIORITIES

STATE SUMMARY

MENTAL HEALTH			2002 ADDITIONAL		2003 ADDITIONAL		2004 ADDITIONAL		2005 ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Day Treatment			195,000						
Non-	Intensive Outpatient			168,800	-	67,520	-	23,630	-	31,180
Residential	Day Rehabilitation			131,219	-	383,031	-	690,490	-	880,568
Services	Outpatient			505,073	-	414,495	-	251,367	-	415,071
	Med. Management			74,114	-	297,947	-	2,987	-	5,631
	Psych. Testing			-	-	15,000	-	28,000	-	1,860
	Vocational Support			-	-	40,000	-	112,880	-	-
	Day Support			12,000	-	60,000	-	2,340	-	59,820
Residential	Secure Residential			175,000	-	175,000	-	-	-	-
Services	Intermediate Res.			454,356	-	445,977	-	613,251	-	355,448
	Psych. Res. Rehab.			810,968	-	1,590,998	-	766,500	-	-
Cornerstone	Emergency*			2,118,604	-	2,202,951	-	475,345	-	422,138
	Community Support			1,144,417	-	805,631	-	248,056	-	518,419
	ACT			294,600	-	234,000	-	-	-	-
	Prevention			300,000	-	178,620	-	132,474	-	160,848
Other*				764,000	-	116,549	-	37,100	-	417,600
TOTAL ADULT			-	7,148,151	-	7,027,719	-	3,384,420	-	3,268,583
CHILDREN	Pro Partner - MH			934,800	-	988,620	-	288,000	-	79,858
Services	Day Treatment - MH			-	-	125,575	-	-	-	-
	Home-Based - MH			95,000	-	95,000	-	53,000	-	-
	Respite Care - MH			25,000	-	15,000	-	33,100	-	76,700
	Ther. Cons. - MH			-	-	-	-	-	-	42,000
	Outpatient - MH			314,750	-	42,508	-	3,217	-	12,629
	Med. Mgmt - MH			64,320	-	19,280	-	2,508	-	5,166
	Intensive OP - MH			80,600	-	80,900	-	3,195	-	6,582
	Youth Assess. - MH			-	-	15,000	-	900	-	73,154
	Other			397,000	-	510,000	-	53,000	-	174,501
TOTAL CHILDREN				1,911,470	-	1,891,883	-	436,920	-	470,590
RATE INCREASE				494,689	-	669,298	-	745,125	-	821,358
ADMINISTRATION				360,763	-	382,131	-	161,134	-	167,820
TOTAL MENTAL HEALTH			-	9,915,073	-	9,971,031	-	4,727,599	-	4,728,351

REGIONAL FUNDING PRIORITIES

STATE SUMMARY

SUBSTANCE ABUSE			2002		2003		2004		2005	
			ADDITIONAL		ADDITIONAL		ADDITIONAL		ADDITIONAL	
LOC	SERVICE	$	CAP.	COST	CAP.	COST	CAP.	COST	CAP.	COST
ADULT	Partial Care		-	-	-	-	-	190,000	-	-
Non-	Intensive Outpatient		-	134,916	-	398,786	-	86,570	-	63,353
Residential	Outpatient		-	351,022	-	425,737	-	215,909	-	212,173
Services	Med. Management		-	250,000	-	36,000	-	-	-	2,160
Residential	Intermediate Res.		-	275,240	-	1,243,997	-	483,420	-	120,000
Services	Dual Disorder Res.		-	1,245,963	-	2,165,020	-	400,000	-	1,085,526
	Short Term Res.		-	1,778,499	-	1,109,418	-	43,899	-	29,701
	Therapeutic Comm.		-	239,974	-	544,031	-	300,000	-	330,000
	Halfway House		-	825,199	-	227,750	-	-	-	-
Cornerstone	Emergency*		-	948,412	-	921,469	-	428,809	-	129,041
	Community Support		-	388,900	-	450,700	-	53,985	-	566,895
	Prevention		-	7,302	-	7,521	-	7,747	-	39,551
	Other		-	886,600	-	84,000	-	485,634	-	113,112
	Prevention		-	887,030	-	562,132	-	270,000	-	115,000
TOTAL ADULT			-	8,219,057	-	8,176,561	-	2,965,973	-	2,806,512
CHILDREN	Ther. Comm. - SA		-	135,320	-	630,000	-	-	-	-
Services	Partial Care - SA		-	76,700	-	-	-	-	-	-
	Halfway House - SA		-	162,067	-	38,000	-	230,000	-	-
	Outpatient - SA		-	195,750	-	63,780	-	58,270	-	46,241
	Intensive OP - SA		-	215,720	-	77,900	-	70,260	-	12,408
	Youth Assess. - SA		-	41,157	-	28,343	-	4,150	-	79,419
	Comm. Support - SA		-	220,000	-	110,000	-	50,500	-	122,830
Other*			-	20,000	-	-	-	672,750	-	492,750
TOTAL CHILDREN			-	1,066,714	-	948,023	-	1,085,930	-	753,648
RATE INCREASE			-	308,326	-	466,955	-	532,512	-	588,665
ADMINISTRATION			-	394,772	-	417,424	-	215,587	-	192,615
TOTAL SUBSTANCE ABUSE			-	9,988,869	-	10,008,963	-	4,800,002	-	4,341,440
TOTAL ALLOCATION			-	19,903,942	-	19,979,994	-	9,527,601	-	9,069,791

ATTACHMENT 3

Medicaid Coverage of Substance Abuse Services

MEDICAID COVERAGE OF SUBSTANCE ABUSE TREATMENT UNDER REHABILITATION OPTIONAL SERVICES PROPOSAL

May 10, 2000

The Medicaid Rehabilitation Option (MRO) is an amendment to the State's Medicaid Plan that permits Federal Financial Participation (FFP) for "optional" services within the array of Medicaid services provided by the State. It is proposed that adult substance abuse services (specific service(s) and eligibility criteria to be determined) be added to the current "optional" services (MRO) array implemented as a result of LB752 enacted in 1995.

I. PURPOSE

- To provide Substance Abuse Rehabilitative services to the Medicaid eligible population.
- To maximize Federal Funding available for Nebraska's Substance Abuse System.
- To use Federal participation funds to expand and increase access to Substance Abuse services in Nebraska through an enhanced array of services.
- To build upon and further strengthen the partnership with local government entities (Regions) for the planning and implementation of the Substance Abuse System.

II. PRINCIPLES *I* PARAMETERS

- LB 880-99 requires that this program be implemented in a revenue neutral manner.
- The financing mechanism will remain consistent with State statutes that established the roles and responsibilities of the six Regional Mental Health and Substance Abuse Governing Boards.
- Federal matching funds will be directed to Substance Abuse Community Aid and used to increase the capacity of the Community-based Substance Abuse Service System. (Legislative line item budget for Federal reimbursement of Substance Abuse optional services). This remains consistent with current MRO Federal participation.
- Ensure that individuals who are non-Medicaid eligibles continue to be served

in the Community-based Substance Abuse Service System.

- Ensures the fiscal integrity of the Community-based Substance Abuse System. Any increase in demand for Medicaid eligibles will not place the service system in financial jeopardy.

- Ensures that administration and implementation of the program is managed by the Division of Mental Health, Substance Abuse and Addiction Services through an Administrative Services Only contract for managed care. This is consistent with current management of MRO services (as approved by the Policy Cabinet) and with the implementation of MRO services Cooperative Agreement between agencies.

- Demonstrates that the use of an ASO contract for managed care maximizes the efficient use of Substance Abuse funding and the appropriate utilization of service(s) in the public non-profit system versus a capitated for profit managed care entity.

- The model will be consistent with the current MRO system that has been reviewed and approved by the HHSS administration and has been in operation since 1995.

- Ensures Division monitored contracts with the six Mental Health and Substance Abuse Regions for the planning and provision of substance abuse optional services. This is consistent with current statute.

- Is consistent with the annual local planning process and annual plan of expenditures for the delivery of substance abuse services statewide.

- Assures budget neutrality by estimating the number of units purchased annually through the annual planning process and is implemented contractually by the Division.

- Ensures expansion of Substance Abuse services. Current MRO services have generated approximately $5 million which has been used to expand services.

III. POLICY CABINET ADMINISTRATIVE DECISION POINTS

1. Agreement and commitment to reinvest FFP to the Nebraska Behavioral Health System.

2. Agreement to seek a State Plan Amendment with a waiver as an alternative strategy.

3. To manage care / authorize services through the Nebraska Behavioral Health System Administrative Services Only contract.

4. To include representatives from the Division of Mental Health, Substance Abuse and Addiction Services in all communications *I* discussions with HCFA with respect to MRO services, Plan vs Waiver discussions. Stakeholder input is essential.

5. To maintain the integrity of Community-Based funding to ensure services to the Non-Medicaid population.

6. To redefine "medical necessity" with respect to Substance Abuse and Rehabilitation-type services. This is consistent with other States definitions and standards regarding Rehabilitation Services.

7. To authorize the inclusion of Substance Abuse *I* TANF dollars into the funding stream.

8. To assure recognition of Certified Alcohol and Drug Abuse Counselors in delivery of services and in making treatment referrals without Supervising Practioner. (Reference: Iowa and Missouri Plans).

REVISED STATUTES
OF
NEBRASKA

COMPRISING ALL THE STATUTORY LAWS OF A GENERAL NATURE IN FORCE AT DATE OF PUBLICATION ON THE SUBJECTS ASSIGNED

TO

Sections: 71-5042 to 71-5052

REHABILITATION AND SUPPORT MENTAL HEALTH SERVICES INCENTIVE ACT

Published by the Revisor of Statutes

Rehabilitation and Support Mental Health Services incentive Act.

Sections: 71 -5042 to 71 -5052

71-5042
Act, how cited.
Sections 71-5042 to 71-5052 shall be known and may be cited as the Rehabilitation and Support Mental Health Services Incentive Act.
Source:
Laws 1995, LB 752, **§** 1.

71-5043
Legislative findings.

The Legislature finds and declares that:
(1) Community-based mental health services substantially enrich the lives of persons with mental illness and enable such persons to become more productive and involved members of society and the provision of such services supports the intent and purposes of the family policy objectives prescribed in sections 43-532 to 43-534;

(2) Rehabilitation and support services are needed in communities to provide persons disabled by severe and persistent mental illness with the opportunity for rehabilitation, housing, work, and supportive care;

(3) A supplemental program to the Nebraska Comprehensive Community Mental Health Services Act should be implemented to provide incentives for the development of rehabilitation and support services;

(4) The Department of Health and Human Services is the state mental health authority and is the primary state agency responsible for the planning and development of community-based rehabilitation and support mental health services in Nebraska. The Department of Health and Human Services Finance and Support is the primary state Medicaid authority. It is the intent of the Legislature that matching federal funds through the Medicaid rehabilitation option will be used to develop middle-intensity, community-based services for Nebraska's with severe, persistent, and disabling psychiatric disorders;

(5) All available federal, state, and private resources, including specialized managed care for Nebraskans with severe, persistent, and disabling psychiatric disorders, should be effectively utilized; and

(6) Too few appropriately trained mental health professionals are available to meet the present and future needs of Nebraskans with severe, persistent, and disabling psychiatric disorders.

Source:
Laws 1995, LB 752, **§** 2; Laws 1996, LB 1044, **§** 701.
Operative date January 1, 1997.

71-5044

Terms, defined.

For purposes of the Rehabilitation and Support Mental Health Services Incentive Act:
(1) Departments means the Department of Health and Human Services and the Department of Health and Human Services Finance and Support;

(2) Medicaid rehabilitation option means the agreement pursuant to federal law allowing matching federal funds to be available for middle-intensity, community-based services for Nebraskans with severe, persistent, and disabling psychiatric disorders;

(3) Mental health regions means the regions as defined in section 71-5002; and

(4) Rehabilitation and support services means services intended to provide persons disabled by severe and persistent mental illness and their families with the knowledge, skills, and support necessary to maximize independent functioning and participation in society and may include, but is not limited to, case management services, residential rehabilitation services, community-living services, residential support services, and vocational support services.

Source:
Laws 1995, LB 752, § 3; Laws 1996, LB 1044, § 702.
Operative date January 1, 1997.

71-5045
Agreements for rehabilitation and support services.

The departments may enter into agreements with mental health regions, other public authorities, or private organizations to provide rehabilitation and support services, including sharing resources to provide the nonfederal matching funds for services provided pursuant to the Medicaid Rehabilitation Option. State funds shall not be used for capital construction. When entering into agreements for the provision of rehabilitation and support services, the departments shall consider the availability of such services and the needs of persons within the area to be served. The Rehabilitation and Support Mental Health Services Incentive Act does not prevent the provision of similar services under authority of the Nebraska Comprehensive Community Mental Health Services Act.

Source:
Laws 1995, LB 752, § 4.

71-5046
Fees.

Persons receiving rehabilitation and support services pursuant to the Rehabilitation and Support Mental Health Services Incentive Act shall be charged fees in accordance with their ability to pay in the same manner and at the same rate as provided in section 71-5014.

Source:
Laws 1995, LB 752, § 5.

71-5047
Audits, reports, and plans required; rules and regulations.

The departments shall require audits, reports, and plans as they deem necessary to supervise and monitor agreements made pursuant to the Rehabilitation and Support Mental Health Services Incentive Act. The departments shall provide accountability for all sources and expenditures of funds for all organizations receiving any funds under the act. The departments shall adopt and promulgate rules and regulations necessary to carry out the act.

Source:
Laws 1995, LB 752, § 6.

71 -5048
Medicaid funding; Department of Health and Human Services Finance and Support; duties.

The Department of Health and Human Services Finance and Support shall take all lawful actions which would provide Medicaid funds for the support of both treatment for persons with mental illness and rehabilitation and support services. Any such funds made available will be used to fund contracts between the State of Nebraska and service providers (1) for providing treatment services in support of the provision of rehabilitation and support services under the Rehabilitation and Support Mental Health Services Incentive Act, (2) for the actual provision of rehabilitation and support services, and (3) for services under Title XX of the federal Social Security Act, as amended.

Source:
Laws 1995, LB 752, § 7; Laws 1996, LB 1044, § 703.
Operative date January 1, 1997.

71-5049
Federal Medicaid Rehabilitation Option; federal waivers; application and implementation.

The Department of Health and Human Services Finance and Support, in consultation with the Department of Health and Human Services, professional provider organizations, advocates, consumers, and families of persons with severe, persistent, and disabling psychiatric disorders, shall apply for and implement the federal Medicaid rehabilitation option and apply for any necessary waivers of federal law, with the goal of providing more effective community-based services, preventing unnecessary and expensive hospitalization, and promoting more effective utilization of the state's inpatient psychiatric facilities. The state may apply such in a revenue-neutral manner relative to the General Fund. The state shall cooperate with local governmental subdivisions to generate matching funds for

Medicaid Rehabilitation Option services with local approval.

Source:
Laws 1995, LB 752, § 8; Laws 1996, LB 1044, § 704.
Operative date January 1, 1997.

71-5050
Departments; report required.

The departments shall submit a report on the status of the application for the Medicaid rehabilitation option by September 30, 1995, to the Governor and the Health and Human Services Committee of the Legislature.

Source:
Laws 1995, LB 752, § 9.

71-5051
Interdisciplinary professional staff administrative model; adopt policies for use.

The Department of Health and Human Services shall adopt policies to require all state-funded residential psychiatric services operated by the department to utilize an interdisciplinary professional staff administrative model. All categories of professional staff involved in psychiatric rehabilitation services in the regional center shall be integrated into the administrative structure of the regional center if qualified by their direct administrative or management experience or training. Preference shall be given to the most cost-efficient use of professional staff in administrative positions or roles.

Source:
Laws 1995, LB 752, § 10; Laws 1996, LB 1044, § 705.
Operative date January 1, 1997.

71-5052
Act; how construed.

It is not the intent of the Legislature to
create entitlement by virtue of enacting the Rehabilitation and Support Mental Health Services Incentive Act.
In the event the act is found to create an entitlement or the acceptance of federal funds is found to create an entitlement, the departments shall immediately limit the scope of services provided or the number of people eligible for services so that the overall state contributions to the program beyond the appropriated amounts are not required to be increased.

Source:
Laws 1995, LB 752, § 11.

71 -5053
Legislative Intent.

It is the intent of the Legislature to ensure that the level of care provided at the regional centers is maintained at a sufficient level to effectively serve persons with mental illness or addiction to alcohol or a controlled substance in need of services as long as the demand for such services exist. It is the further intent of the Legislature to ensure existing regional center services are maintained until such services have been developed and are available at the community level to provide needed care and support to all persons with mental Illness or addiction to alcohol or a controlled substance who are appropriate for care in a community-based, less restrictive setting. This will allow the regional centers to transition current psychosocial rehabilitation levels of care to the community and assume the appropriate role of providing inpatient hospital care and secure residential services within a full continuum of behavioral health services.

Source:
Laws 1998, LB 1354, § 1.

71-5054
Repealed. Laws 2000, LB 1135, s. 34.

71 -5055
Behavioral health community-based services; recipient
Any person who does not meet criteria for inpatient or secure residential level of care or any person who is discharge-ready from a regional center shall be referred to and have priority status for receiving immediate appropriate public behavioral health community-based services.

Source:
Laws 1998, LB1354,§3.

71-5056
Regional Center Services; reduction; Department of Health and Human Services; report.

On or after July 1, 1998, and at such time as the utilization of available community-based services, including the development and use of state-operated, community-level services by the Department of Health and Human Services where such services would not otherwise be provided, has sufficiently reduced the demand for regional center services to the point that the services may be offered at a reduced level, the Department of Health and Human Services, before reducing such services, shall issue a report to the Governor, the Clerk of the Legislature, the chairperson of the Appropriations Committee of the Legislature, and the chairperson of the Health and Human Services Committee of the Legislature. The report shall identify the community services involved and certify that such services possess sufficient capacity and capability to effectively replace the service needs which otherwise would have been provided at a regional center. The report will be issued no later than thirty

days prior to any action taken to reduce any regional center service.

Source:
Laws 1998, LB 1354, § 4.

71 -5057
State Regional Center Employees; how treated.

As behavioral health services are transitioned from regional centers to community services and new institutional services, state regional center employees shall have the opportunity to continue as state employees to deliver replacement services in the state behavioral health system. The Department of Health and Human Services shall provide to these employees the training and support necessary to transition into new state positions in the state behavioral health system.

Source:
Laws 1998, LB 1354, § 5. LB 523,s. 18.

ATTACHMENT 4

Medicaid Draft Plan for
Assisted Living Support Services

MEDICAID DRAFT PLAN FOR ASSISTED LIVING SUPPORT SERVICES

December 7, 2000

TO: George Hanigan Ron Sorensen

FROM: Robert J. Seiffert, Administrator Medicaid Division

RE: Personal Care Services and Housing for Persons with Severe and Persistent Mental Illness

Attached please find a draft document entitled, "Assisted Living Specialized Support Services". Mary Jo Iwan and I have drafted this document, as a policy coverage change, to aid in our efforts at securing additional funding to improve services in certain licensed assisted living facilities that primarily serve persons with severe and persistent mental illness.

The addition of assisted living specialized support services Is being considered because the state's grant assistance program for persona in assisted living services no longer provides the necessary revenue to a provider to provide the services necessary to sustain individuals with behavioral health needs. The current grant rate of $782 per month, with the resident allowed $60 for personal needs, leave a net of $722 to the provider. It is our intent to supplement that grant allowance with the assisted living support services described in the attached document Although we have not finalized a recommended rate per month for this service, we believe that a rate of $300 per month In the urban areas, and $200 per month in the rural areas would go a long way to enhancing our service delivery.

By adding these services under our Medicaid State Plan, we will be able to draw approximately
80% federal matching funds for the cost of these additional services. If we can put this in place,
I believe we can stabilize the current housing arrangements that helps support many persons
with severe and persistent mental illness in the State. However, I believe we must go further
than simply adding this service to our Medicaid Plan.

In the State, we must begin to develop new housing units, so that we can begin reducing the use of the State Regional Centers for persons with behavioral health care needs. Under the assumption that we may need 400 new assisted living housing units in the State, I believe we could build a program utilizing either our intergovernmental transfer trust fund dollars, or our tobacco settlement dollars, to aid in the development of new housing units, If you assume we need 400 units statewide, at a cost of $75,000 per unit, $30 million would be required to build that many assisted living units. However, I believe providers could be challenged

to support half of that cost with the balance being provided through a state grant program.

The advantage to the State providing part of the capital cost of construction, through an RFP process, would be that it could completely control the providers, locations, architectural, and financial feasibility of each housing project. This should insure that In the long run, we will reduce the use of the regional centers by persons age 22-64, where the State receives no federal matching funds. I believe that it is not only possible to reduce the overall cost of caring for these Individuals with good housing and a good housing supportive service, but in addition, we can receive 60% federal matching funds in doing it We should easily achieve a net reduction in the use of state general funds.

I hope this memorandum has outlined what I believe could be an exciting new service possibility for the State of Nebraska.

G0340K

Attachment

cc: Mary Jo Iwan
Special Services for Children and Adults

ASSISTED LIVING SPECIALIZED SUPPORT SERVICES

PURPOSE:

Assisted Living Specialized Support Services provide assistance with Activities of Daily Living, Instrumental Activities of Daily Living or administering medication to Medicaid-eligible persons in Assisted Living who have been determined to need such assistance.

DESCRIPTION OF SERVICES:

Assisted Living Specialized Support Services are services Individuals would normally perform for themselves If they did not have a disability or functional limitation. Services may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing so that the person performs the task by him/herself. Such assistance most often relates to performance of ADL's and IADL's. ADLs include eating, bathing, dressing, toileting, transferring and maintaining continence. IADL'S capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management Assistance with taking medication is included in accordance with Nebraska's Assisted Living Licensing Regulations.

There are two tracks available to clients:

1. **CONSUMER DIRECTED SERVICES:** Under this model, clients who have the capacity and desire to manage their own providers may train the provider according to their personal preferences and supervise and direct the provision of Assisted Living Specialized Support Services as specified in the Resident Services Agreement. HHS maintains responsibility for ensuring that providers meet standards and with the assistance of the client, monitoring services delivery. Resident Services Agreements must specify the tasks, who will perform the tasks, and when the tasks will be performed, and the role of the client in training, supervision and direction.

2. **TRADITIONAL SERVICES DELIVERY:** For clients not selecting consumer directed services, providers will perform tasks as outlined in the Resident Services Agreement. The Resident Services Agreement (RSA) must specify the tasks, who will perform the tasks, and when the tasks will be performed.

ASSESSMENT PROCESS AND PLAN (Resident Services Agreement):

1. Assisted living facilities will complete a checklist indicating the needs of a Medicaid-eligible individual.
2. The checklist should be submitted to the Assisted Living case manager who will verify needs based on past assessments of the client or who will conduct an assessment visit with the client to determine needs,
3. If the client has a need indicated on the checklist, the Assisted Living case manager will determine the client's preference for consumer-directed or traditional services delivery.
4. The client will also select the Assisted Living Specialized Support Services provider he/she wishes to use.
5. The Assisted Living case manager will document the client's choice of provider.
6. The Assisted Living case manager, client and provider will meet to develop and agree upon the specific tasks to be performed, the person(s) carrying out the tasks and the times the tasks will be performed. If the client has selected consumer-directed services, the role of the

client in providing training on personal preferences and supervision, direction, recording and monitoring services delivery will be determined.

7. All decisions mad. in #6 will be documented in the Resident Services Agreement and updated as needed.

REASSESSMENT:

The client's needs shall be reassessed on an annual basis or at the time a change in functioning occurs.

PROVIDER STANDARDS:

An assisted living facility may become an Assisted Living Specialized Support Services provider when it:

1. Is licensed by the State of Nebraska.
2. Employs staff who are trained in performance of ADL's and IADL's and, in relation to medication assistance, are certified as Medication Aides.
3. Agrees to allow clients to self-direct services when they have made that choice.
4. Has been determined by HHS to have trained staff and sufficient numbers of staff In accordance with HHS Regulations.
5. Enters into a Medicaid provider agreement to provide Assisted Living Specialized Support Services.

REIMBURESEMENT

ALSSS is based on a monthly rate of _____. This rate includes all tasks listed under Description of Services. In the event the client is not a resident for a full month, the rate will be pro-rated on a daily basis

MONITORING

HHS will re-certify providers on an annual basis by updating the initial provider approval information and reviewing the provider's performance over the previous year. This will include review of information submitted by clients who have chosen to self-direct services and any complaints and their resolution.

AOI75C

TRANS-LETTER, State Medicaid Manual, Part 4 (HCFA-Pub. 45-4), Transmittal No. 72, January 1, 1999

State Medicaid Manual, Part 4 (HCFA-Pub. 45-4), Transmittal No. 72, January 1, 1999

Revised MATERIAL	REVISED PAGES	REPLACED PAGES
Secs. 4480 — 4480 (Cont.)	4-495 - 4-496 (2 pp.)	4-495 — 4-496 (2 pp.)

CHANGED IMPLEMENTING INSTRUCTIONS -- EFFECTIVE 11/11/97

Section 4480, **Personal Care Services. >** As a result of the personal care regulation published November 11, 1997, we are expanding upon our definition of **personal care services** by deleting reference to physical tasks while referring to assistance with both activities of daily living (ADLs) and instrumental activities of daily living (IADLs), including assistance with cognitive tasks We anticipate that this clarification will help States in defining personal care services to allow for greater flexibility and to make it easier to address changes that may occur in the definition and delivery of personal care services.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

4480. <PERSONAL CARE SERVICES>
O1-99 REQUIREMETNS AND LIMITS APPLICABLE TO SPECIFIC SERVICES
4480

A. General.-- Effective November 11, 1997, HCFA published a final regulation in the Federal Register that removed <personal care SERVICES> from regulations at 42 CFR 440.170 and added a new section at 42 CFR 440.167, “Personal Care Services in a home or other location.” The final rule specifies the revised requirements for Medicaid coverage of personal care services furnished in a home or other location as an optional benefit. This rule conforms to the Medicaid regulations and to the provisions of § 13601 (a)(5) of the Omnibus Budget Reconciliation Act (OBRA) of 1993, which added § I *905(a)(24)* to the Social Security Act to include payment for personal care services under the definition of medical assistance Under §1905(a)(24) of the Act, States may elect, as an optional Medicaid benefit,<Personal care services> furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), or institution for mental disease. The statute specifies that personal care services must be (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the

individual's family; and (3) furnished in a home or other location.

B. Changes Made by Final Regulation. -- **<Personal care services>** may now be furnished in any setting except inpatient hospitals, nursing facilities1 intermediate care facilities for the mentally retarded, or institutions for mental disease. States **choosing** to provide personal care services may provide those services in the Individual's home, and, if the State so chooses, in settings outside the home.

In addition, services are not required by Federal law to be provided under the supervision of a registered nurse nor does Federal law require that a physician prescribe the services in accordance with a plan of treatment. States are now permitted the option of allowing services to be otherwise authorized for the beneficiary in accordance with a service plan approved by the State.

C. Scope of Services. -- **<Personal care services>** (also known as personal assistance services) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all **ages** which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. **Personal care services** can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered **personal care services.**

1. Cognitive Impairments. -- An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. **<Personal care services>** may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task.
For example an individual may no

longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

2. Cosumer-Directed Services. -- A State may employ a consumer-directed service delivery model to provide **<personal care services>** under the personal care optional benefit to individuals in need of personal assistance who are not cognitively impaired and have the ability and desire to manage their own providers. In such cases, the Medicaid beneficiary may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the **personal care services** and, if necessary, fire the provider. The State Medicaid Agency maintains responsibility for ensuring the provider meets State provider qualifications (see E below) and for monitoring service delivery.

D. Definition of Family Member. **--<Personal care services>** may not be furnished by a member of the beneficiary's family. Under the new final rule, family members are defined

to be “legally responsible relatives.” Thus, spouses of recipients and parents of minor recipients (including stepparents who are legally responsible for minor children) are included in the definition of family member. This definition necessarily will vary based on the responsibilities imposed under State law or under custody or guardianship arrangements. Thus, a State could restrict the family members who may qualify as providers by extending the scope of legal responsibility to furnish medical support.

E. Providers.--States must develop provider qualifications for providers of **<personal care services>** and establish mechanisms for monitoring the quality of the service. Services such as those delegated by nurses or physicians to personal care attendants may be provided so long as the delegation is in keeping with State law or regulation and the services fit within the **personal care services** benefit covered under a State’s plan. Services such as assistance with taking medications would be allowed if they are permissible in States’ Nurse Practice Acts, although States need to ensure the personal care assistant is properly trained to provide medication administration and/or management.

States may wish to employ several methods to ensure that recipients are receiving high quality **<personal care services.** For example, States may opt to a criminal background check or screen personal care attendants before they are employed. States can also establish basic minimal requirements related to age, health status, and/or education and allow the recipient to be the judge of the provider’s competency through an initial screening. States can provide training to personal care providers. States also may require agency providers to train their employees. States can also utilize case managers to monitor the competency of personal care providers. State level oversight of overall program compliance, standards, case level oversight, attendant training and screening, and recipient complaint and grievance mechanisms are ways in which States can monitor the quality of their personal care programs. In this way, States can best address the needs of their target populations and develop unique provider qualifications and quality assurance mechanisms.

ASSISTED LIVING FACILITIES

MI/MR-33

Central City	L.I.V.E., Inc.
Columbus	Walles House
Genoa	Genoa Haven Home
Genoa	Pawnee Hills Assisted Living
Grand Island	Precious Time
Hastings	Marjo Manor, L.L.C.
Hastings	South Central Behavioral Ser. Res. Rehab. II House
Inavale	Gala Gardens Manor
Lexington	Alternative Life Style I, 913 West 5th St.
Lexington	Alternative Life Style ll, 5ll West Spruce St.
Lincoln	Bel-Air Home
Lincoln	Champion Home Residential Assisted Living
Lincoln	O.U.R, Homes 2445 R St
Lincoln	O.U.R. Homes, 2144 Washington St.
Lincoln	O.U.R. Homes Domiciliary, 1900 A Street
Lincoln	O.U.R> Homes Domiciliary, 1225 South 17th St
Lincoln	Prescott Place, Inc.
Lincoln	Serenity Place
Lincoln	The Victorian
Norfolk	Improved Living, Inc. House 1, 114 So 9th St
Norfolk	Improved Living, Inc. House 2,203 No 9th St
Norfolk	Park Place
Omaha	Community Alliance-Alliance House
Omaha	Community Alliance-Arbor House
Omaha	Community Alliance-Miami House
Omaha	Community Alliance-Vinton House
Omaha	Golden Manor
Omaha	Omaha Supportive Living
Omaha	Paxton Manor (large percentage)
Omaha	Princess Anne Residential Care Facility
Omaha	Toth Domiciliary Facility
Scottsbluff	Cirrus House
Wayne	Kirkwwod House

4/11/00

ATTACHMENT 5

Region I Proposal for Inpatient Services

Region I Behavioral Health:
A Community Action Plan for
Mental Health Board Commitment

A Collaborative Proposal between Region I
And
Regional West Medical Center

The following people have participated in the development and presentation of this proposal to the Nebraska Legislature for consideration.

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1509 1st Avenue
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PROJECT DEFINITION

This community action plan is an effort in the Panhandle of Nebraska to provide a full community based continuum of care for individuals committed by the Board of Mental Health. An integral service in this continuum is the provision of local twenty four-hour care for individuals post commitment. This proposal would allow for the provision of extended inpatient services and the addition of secure residential services at Regional West Medical Center. These services would be supported by a comprehensive array of emergency and other community based services within the Region.

RATIONALE

This collaborative proposal from Region I Service Administration and service providers in the Panhandle addresses problems encountered due to barriers in the current system and outlines some of the opportunities that would greatly enhance the care and well-being of those in the area with mental illnesses and substance abuse addictions.

BARRIERS

1. Transportation

   - A person committed to a Hastings Regional Center must be transported over 350 miles away from home.
   - Families of those committed to Hastings Regional Center are unable to afford the time and money to travel to HRC.
   - Law enforcement in small rural communities is diminished when the only officer on duty has to transport an individual 100 to 150 miles one way to the regional hospital because the person could not be stabilized in the local community.
   - Secure transportation from Region I to Hastings Regional Center is costly to the counties in the Panhandle.

2. Medication

   - The medication received at discharge from the Regional Center is often not enough to sustain the individual until care with a local psychiatrist can be established.
   - The local psychiatrists are not involved in the stabilization period during hospitalization at the Regional Center and seek to utilize newer psychotropic medication upon discharge.

3. Loss of Resources

   - Patients lose resources when they are in the Regional Center for an extended period of time including such things as their housing and Medicaid benefits.

- Patients' support system erodes during extended stays out of the area.

4. Dual Diagnosis Care
   - There is no residential care available in the region for a person with a dual diagnosis.
   - Residential care for dual diagnosis in the eastern part of the state has extended waiting lists up to 9 months.

5. Discharge Planning
   - Discharge plans from a Regional Center, not familiar with the local services and geographic distances, are not followed consistently because they are not realistic.
   - Appointments for follow-up do not insure care will be utilized which results in unnecessary re-hospitalization.
   - Delayed receipt of discharge plans interferes with treatment follow-up.

OPPORTUNTIES

1. Coordinated Stabilization within the Region
   - Small rural communities can coordinate with a system of care that provides the ability to stabilize more of the patients in the local community.
   - Availability of extended care within the region decreases trauma to patients and risk to law enforcement officers.

3. Continuity of Care

   - Providing extended care in the region allows for discharge planning that can be inclusive of realistic and appropriate community services.
   - Geographic barriers can be considered in the design of the reasonable continued care plan.
   - A plan for wraparound can be developed involving appropriate community providers prior to discharge.
   - Connections to care providers such as the community support worker can be made prior to discharge to improve the likelihood that the patient utilizes the follow-up care.
   - Local case management can follow the discharge plan and trouble shoot difficulties as they arise to avoid further crisis development.
   - Patients in extended care can be gradually reintegrated into their own communities with access to social opportunities, support groups, daily living resources such as grocery stores, and recreational resources. Currently patients are being integrated into the Hastings community.

3. Decrease Length of Stay

   - Utilizing extended care within the region will provide the ability to move patients into familiar environments more quickly.

- Consumers report that without threat of separation from family and support systems, they would seek care in a more timely fashion prior to need for crisis intervention. Thus, stabilization and reintegration could be achieved in shorter time without ties being severed.

4. Family and Significant Others Involvement

- Families of patients in extended care can be involved in supportive treatment during hospitalization.
- Patients can maintain family ties through visitation and therapeutic passes on a regular basis.
- Significant others such as AA sponsors, ministers, natural helpers can be involved when the patient is available locally rather than beyond reach because of distant hospitalization.

HISTORY

The recent Supreme Court decision in Olmstead v. L.C. (1999), provides an important legal framework for our mutual efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. The Court's decision clearly challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost effective community based services. The U.S. Dept. of Health and Human Services, in its letter to State Medicaid Directors dated January 14, 2000 states that the HHS Administration agrees that no one should have to live in an institution or a nursing home if they can live in the community with the right support. It is to this end that Region I supports RWMC's proposal to provide inpatient hospitalization and secure residential services. As stated in the rationale, this will allow for a more rapid integration of patients back into the community and improved coordination of needed support services.

Nebraska has been progressive in its belief that all citizens with disabilities should have the opportunity to live as independently as possible in the least restrictive setting. In 1992 and again in 1993, Legislative resolutions required the review of the mental health and substance abuse system. This resolution created a task force to examine the state's mental health services and make recommendations. Members of the task force included Senators Robak, Wesley, Pirsch, Day and Moore. Their recommendations are summarized as follows:

- Focus on the needs of consumers
- The system needs to be cost effective
- There is a need for more public education regarding mental illness
- Improve access to services in rural areas
- Increase funding for community based services
- Expand the availability of youth services
- Improve collaboration among agencies, providers, and other participants in the system

Based on these recommendations, state agencies through input from a wide array of stakeholders, began redesigning and improving the mental health and substance abuse system. That system, now known as **The Nebraska Behavioral Health System**, is constructed within the following framework:

1. **Creation of a comprehensive and unified service delivery system.** The system must provide access to services that meet consumers needs and assist consumers to transition between services.
2. **The funding and resource allocation system must be improved.** The funding process needs to be flexible and allow resources to be shifted based on consumer and community need.
3. **The design and evaluation of the system must focus on the needs of the consumer.** Involvement of consumers at every level of design and evaluation will result in available resources and services to be based on consumer needs.
4. **The system must identify outcomes and improve accountability for the delivery of services.** Outcomes and performance indicators for both consumers and the system are essential to ensure that those responsible for delivering services and managing the system are accountable for its performance.
5. **The system must have the ability to effectively manage its information.** An information system must be developed that provides the information necessary to deliver and assess clinical care as well as manage the system.
6. **Continuous quality improvement must be integral to the system.** Standardized admission and discharge criteria, improved training and continuous quality processes must be implemented.

BEHAVIORAL HEALTH SERVICES

Each Region in the State is charged with developing a comprehensive array of services designed to meet the needs of consumers and the community. The goal of each Region is to develop a balanced system that will provide consumers the care they need in the least restrictive setting. This in turn allows consumers to live independently in the community resulting in reduced cost to the system.

REGIONAL WEST MEDICAL CENTER PROPOSAL

Program History

The Behavioral Health Center at Regional West Medical Center has the history of providing quality inpatient psychiatric treatment services for the past 16 years to individuals within Region I. The Behavioral Health Center currently operates a continuum of behavioral health services including adult inpatient, partial hospitalization (day treatment), and drug and alcohol education. In addition, child/adolescent inpatient, partial hospitalization (day treatment) and residential services are provided. The Behavioral Health Center is affiliated with Partners in Behavioral Health, an outpatient

practice consisting of three psychiatrists, a psychologist and several licensed mental health professionals. In the recent past, the practice has been to send all patients committed by the Board of Mental Health to Hastings Regional Center. Many of these patients can receive high quality care at Regional West Medical Center, without traveling outside of the Region I area. The Behavioral Health Center has the ability to provide inpatient and secure residential services to committed patients who meet specific admission criteria to be defined later in this plan. Much of the infrastructure necessary to implement these services is already in place and minimal preparation would be necessary to begin accepting patients post commitment into one or both of these levels of care.

In fiscal year 1999 - 2000, 43 committed and 5 voluntary patients were sent out of Region I for inpatient and/or secure residential treatment at Hastings Regional Center with an average length of stay of 52 days. In fiscal year 2000 - 2001, another 20 patients were sent. According to the proposed admission and exclusion criteria approximately 70% of these 63 patients could have been treated at Regional West Medical Center with an anticipated average length of stay .reduced to 30 days.

Target Population

The Behavioral Health Center, offers services to consumers without discrimination on the basis of race, color, religion, gender, national origin, disability or any other characteristic protected by law. The target population for the proposed services would include patients who have been committed by the Board of Mental Health for treatment with a DSM IV diagnosis reflecting a serious mental illness or secondary substance abuse. Patients who would be excluded from these services include:

- ◊ patient's who have a primary diagnosis of substance abuse,
- ◊ sexual perpetrators,
- ◊ patients with an IQ of 60 or less with behavioral dyscontrol
- ◊ and patients requiring an anticipated length of stay in excess of 45 days.

These referrals would continue to be made to Hastings Regional Center.

Program Capacity

The unit will have sixteen total beds. Six of these beds will be devoted to the Adolescent Residential Program. The other ten beds will be devoted to inpatient. The unit provides physical separation between areas housing adult and child/adolescent patients and yet provides flexibility to expand unit capacity in inpatient programs as variances in census warrant. In 1999 the average daily census for 24 hour patients (excluding child/adolescent residential) at the Behavioral Health Center was 5.8. Year-to-date 2000 this totals 5.95. With the addition of an estimated 30 patients for an average length of stay of 30 days, the average daily census for 24 hour patients would increase to 8.3. The adult unit is staffed 24 hours a day, 7 days a week. The minimum staffing on any shift is 1 RN and 1 Psychiatric Technician. In addition, the unit is staffed by a psychologist, Clinical Therapist, a Recreation Therapist, and Art Therapist. Daily operations of the unit are overseen by the Clinical Advisor, Clinical Coordinator, Director of Behavioral Health Services and Vice President of Community Network Development.

Proposed Levels of Care

<u>Inpatient</u>:

Acute inpatient care is appropriate when the patient has been evaluated by a qualified mental health professional and determined to have a high degree of dangerousness despite the maximum support at the community level and requires acute hospital level of twenty four hour treatment which is directed toward the stabilization of the acute phase of the patient's illness and/or dangerous impulses. Persons at this level of care have unstable and severe psychiatric symptomatology and require daily review and adjustment of treatment plans.

Entry Criteria: For an inpatient admission to be determined medically necessary, a patient must meet the following:

1. Ongoing acute risk of dangerousness which is demonstrated by:
   Active planning or intent to harm himself/herself or others with inability to provide a valid and reliable safety contract;

   Or
2. Inability to assure his/her own physical safety or the safety of others due to severe disturbance in affect, behavior, thought processes and/or judgement.

   And
3. Patients must be in need of at least one of the following skilled services:

   a) Physical restraint and/or locked seclusion, with direct and continuous observation to assure safety.
   b) Twenty-four hour behavioral monitoring to assure safety, such as monitoring for suicidal or homicidal behaviors. Such behavioral monitoring must require the skill level of a mental health professional.
   c) Continual around the clock nursing and/or medical intervention or behavioral redirection of a frequency and intensity that cannot be provided in an available, less restrictive level of care. This care level includes the ability to amend and adjust the treatment plan on a daily or more frequent basis. Such intervention must require the skill level of a mental health professional.

Continued Stay Criteria: The following must be met:

1. The patient continues to meet the above entry criteria
2. The treatment provided must continue to be the most efficacious available for the patient's condition.
3. A complete plan for transitioning the patient to a lessor level of care must be in place or under rapid development.

Exit Criteria: The consumer has stabilized and no longer meets the above Entry Criteria.

Secure Residential

This level of care is appropriate when the patient requires a secure environment or intensive staff intervention at all times to ensure the safety of the patient and/or public. The patient is at high risk for dangerousness if a relapse should occur. These persons may require a specialized setting or treatment capability depending upon the severity of complicating condition (i.e. skilled nursing facility for the medically frail etc.)

Entry Criteria:

1. The patient's risk for harm may be contained with less than 24-hour medical supervision and their condition requires less than daily treatment planning and assessment.

And

2. The patient requires 24-hour behavioral monitoring or therapeutic intervention with the skill level of a mental health or substance abuse professional to contain risk for harm or prevent relapse. This external control must be of a frequency and intensity that cannot be provided in an available, less restrictive level of care and includes a secure locked environment with access to physical seclusion and restraint.

Continued Stay Criteria:

1. The consumer continues to meet the entry criteria

And

2. The treatment provided must continue to be the most efficacious available for the patient's condition.

And

3. The complete plan for transitioning the patient to a lesser level of care must be in place or under rapid development.

Exit Criteria: Precipitating condition, risk for dangerousness or relapse potential have been stabilized and/or contained, with high likelihood that condition can be managed without 24 hour secure environment.

Financial Needs Analysis

Start Up Costs: Much of the infrastructure for services to begin is already in place. The primary need would be for the purchase of additional cirriculum materials in the treatment of seriously mentally ill patients and staff training. Although staff currently deal with seriously mentally ill patients, treatment modalities are directed at stabilization of acute symptoms as opposed to development of skills and support. Treatment of patients will be based on a psychiatric rehabilitation model which is a consumer-oriented model that helps

the consumer identify their treatment goals and the skills and support they will need to develop to achieve their goals. This training would be made available to all providers within the proposed continuum of care.

Estimated Cost of Treatment Services: The estimated cost of service provision per patient day is $335.00. The number of admissions is estimated at 30 per year with an average length of stay of 30 days.

Total Requested: $350,000 to include service provision, additional staff, training and start up costs at Regional West Medical Center..

SERVICE INTEGRATION

The recent Olmstead decision focuses attention on the importance of providing services in a community setting to allow for family and support services to be available to consumers.

Region I is in the process of developing both emergency and non-emergency services to ensure that consumers can:

- Be stabilized and assessed so that only those needing Emergency Protective Custody services will referred to that service.
- Transition to appropriate community based services after a patient is discharged from either inpatient hospitalization or secure residential services.

Additional community based services will be developed in Region I as part of its effort to create a comprehensive behavioral health system. Should funding be allocated for services for commitments at RWMC, the following "emergency stabilization and assessment services" will need to be developed by the end of FY 2002. Emergency stabilization and assessment services are needed specifically in the communities of Chadron, Scottsbluff, Alliance, and Sidney and to some degree throughout the Panhandle to ensure that the proposed RWMC services are used effectively and efficiently.

Stabilization and Assessment Services

- 24-Hour Crises Line
- Mobile/Local Crises Response
- 23/59/Psych Respite
- Detoxification
- Civil Protective Custody

The following "community based transition" services will need development * or expansion*.

Community Based Transition Services

- Emergency Services Coordination*
- Dual-Diagnosis Services*
- Medication Management*

- Short-Term Residential*
- Professional Partner*
- Intensive Outpatient*
- Day-Rehabilitation^
- Assisted Living*
- Outpatient*

RECOMMENDATIONS

- Region I recommends that funding be made available to provide the proposed Regional West Medical Center inpatient and secure residential services in the amount of $350,000.
- Funding for the RWMC services should be an allocation in addition to those that may currently or in the future be allocated to Region I to provide community based services.
- Funding for additional emergency stabilization and assessment and the community transition services received through this proposal should become part of the Region I allocation for community based services, based upon the recommendations included in the Mental Health Substance Abuse White Paper.

COMMUNITY AND CONSUMER LETTERS OF SUPPORT